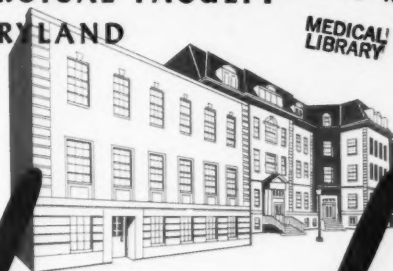




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Official Publication of the
MEDICAL AND CHIRURGICAL FACULTY
OF THE STATE OF MARYLAND

SOUTH BALTIMORE GENERAL
HOSPITAL ISSUE



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ANNUAL MEETING WEDNESDAY THURSDAY FRIDAY APRIL 15 16 17 1959

EFFECTIVE AGAINST MOST STRAINS OF STAPHYLOCOCCUS **CHLOROMYCETIN** COMBATS MOST CLINICALLY IMPORTANT PATHOGENS

Surveys of *in vitro* performance of various antibiotics over the past several years indicate a definite decrease in activity against the staphylococcus. **CHLOROMYCETIN**, however, continues to demonstrate a high degree of potency against this stubborn pathogen.¹⁻⁴ Even the strains responsible for hospital-acquired staphylococcal infections, which are resistant to most other antibiotics, may be sensitive to **CHLOROMYCETIN**.⁵⁻⁹ For this reason, it has been recommended for immediate use in suspected staphylococcal infections in infants, the mothers, and in surgical patients.¹⁰

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CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for long-term infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

REFERENCES: (1) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* 30:175, 1958. (2) Roy, T. E., et al.: *Canad. M. J.* 77:844, 1957. (3) Markham, N. E., & Shott, H. C. W.: *New Zealand M. J.* 57:55, 1958. (4) Royer, A., in Welch, R. & Marti-Ibañez, E.: *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, p. 783. (5) Blair, J. E., & Carr, M.: *J.A.M.A.* 166:1192, 1958. (6) Caswell, H. T., et al.: *Surg., Gynec. & Obst.* 106:1, 1958. (7) Fekety, R., et al.: *Am. J. Pub. Health* 48:298, 1958. (8) Godfrey, M. E., & Smith, I. M.: *J.A.M.A.* 166:1197, 1958. (9) Kessler, J. & Scott, R. B.: *J. Dis. Child.* 96:294, 1958. (10) Shaffer, T. E.: *J. Michigan M. Soc.* 57:851, 1958.

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Maryland

STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 8

February, 1959

NUMBER 2

YOUR MEDICAL FACULTY AT WORK

JOHN SARGEANT, *Executive Secretary*

COUNCIL

The Council of the Medical and Chirurgical Faculty of Maryland met on Tuesday, November 18, 1958, at the Faculty Building and took the following action:

1. Heard a report from the Building Committee which recommended that the Faculty remain in its present location and that the building be renovated.
2. Authorized installation of a telephone line for the National Medical Emergency Service Committee, contingent upon the installation of a Faculty switchboard.
3. Approved various appointments to several committees and boards of the Blue Cross-Blue Shield organizations.
4. Approved for adoption and use throughout the state a Pupil Medical Record Form, which has been the subject of discussion between representatives of the State Education Department and a special Faculty committee.
5. Authorized the closing of the Faculty building on Saturday mornings because of the small use of the business office and library on this day.
6. Approved new terms for Editorial Board appointments, with all members serving three year terms, and two members being named each year. To put this into effect, first appointments will be made on a staggered basis of one, two and three years each.
7. Approved recommendations of the Scientific

Work and Arrangements Committee as follows:

- (a) That the dates of the 1960 Annual Meeting be April 20, 21 and 22.
 - (b) That the 1959 Semiannual Meeting be held at the Commander Hotel in Ocean City, and that serious consideration be given to a smorgasbord luncheon rather than the usual clambake.
8. Adopted Council meeting dates for 1959.
 9. Approved a suggestion that the Medical Impartial Witness panel be reviewed and be subject to change at least once every two years, with the Council chairman authorized to appoint a selection committee to conduct this review.
 10. Accepted with regret the resignation of Everett S. Diggs, M.D. as secretary.
 11. Named William Carl Ebeling, M.D. as secretary to succeed Dr. Diggs.
 12. Approved a revision in paid holidays for staff personnel from 14 to nine.
 13. Stated it could not approve or disapprove a suggested course in anatomy at the University of Baltimore for claim attorneys and insurance adjusters. Also stated that before any expression could be made, information as to the length of course, names of instructors, etc. would have to be provided.
 14. Discussed at some length the question of free choice of physician, as well as the question of corporate practice of medicine.
 15. Named Dr. Diggs a Councillor to take the place of the late Dr. Frank J. Geraghty.

Annual Meeting

MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

APRIL 15, 16, 17, 1959

The Alcazar, Baltimore

The scientific program for the Annual Meeting of the Medical and Chirurgical Faculty is almost complete and at this writing the following prominent speakers are to present papers:

WEDNESDAY AFTERNOON, APRIL 15, 1959, 2:00 P.M.

- DR. CHARLES A. HUFNAGEL, Washington, *Subject Related to Cardiac Surgery.*
DR. WILLIAM DAMESHEK, Boston, *"Leukemia: Present Status."*
DR. RALPH F. BOWERS, Memphis, *"The Surgical Treatment of Chronic Pancreatitis."* (J. M. T. Finney Fund Lecture.)
DR. CHARLES F. WILKINSON, JR., *"Atherogenesis and Lipid Metabolism."*

WEDNESDAY EVENING, 8:30 P.M.

The Alcazar

Medicolegal Symposium.

THURSDAY MORNING, APRIL 16, 1959, 9:15 A.M.

- Representative from the U. S. Bureau of Old Age and Survivors Insurance.
DR. HORACE L. HODES, New York, *Pediatric Subject Related to Staphylococci Infections.*
DR. IVAN L. BENNETT, JR., Baltimore, }
DR. EVAN CALKINS, Boston, } *Panel Discussion on Corticosteroids.*
DR. LAWRENCE E. SHULMAN, Baltimore, }
DR. LAWSON WILKINS, Baltimore, }

THURSDAY, 12:30 P.M.

Round Table Luncheon, Park Plaza Hotel, Baltimore

THURSDAY AFTERNOON, 2:15 P.M.

- DR. JAMES T. PRIESTLEY, Mayo Clinic, *"Surgical Lesions of the Adrenal Glands."* (I. Ridgeway Trimble Fund Lecture.)
DR. EDGAR V. ALLEN, Mayo Clinic, *Subject Related to Peripheral Circulation.*
DR. SAMUEL P. ASPER, JR., Baltimore, }
DR. HERRMAN L. BLUMGART, Boston, } *Panel Discussion on Radioactive Iodine.*
DR. JOSEPH E. RALL, Bethesda, }

THURSDAY EVENING—PRESIDENTIAL DINNER

Sheraton Belvedere Hotel, Baltimore

Cocktails. 6:00 P.M.

Dinner. 7:00 P.M.

General Meeting. 8:15 P.M. Speaker: MILTON S. EISENHOWER, President, The Johns Hopkins University.

FRIDAY MORNING, APRIL 17, 1959, 9:15 A.M.

DR. HARLAN I. FIRMINGER, Baltimore, }
DR. THEODORE E. WOODWARD, Baltimore. } *Clinical Pathological Conference.*
DR. THOMAS B. CONNOR, Baltimore, *"Renal Calculous Disease—Clinical and Metabolic Aspects."*
MR. WILLIAM ALAN RICHARDSON, President of "Medical Economics," *Subject Related to the Economic Phase of Medicine.*

On Wednesday, April 15, 1959, the Woman's Auxiliary to the Medical and Chirurgical Faculty will hold its annual luncheon at the Sheraton Belvedere Hotel. All doctors and their wives are invited to attend this luncheon meeting.

The Council and House of Delegates of the Medical and Chirurgical Faculty will meet at the Alcazar on Wednesday morning, April 15, 1959. The second session of the House of Delegates will also be held at the Alcazar on Friday afternoon, April 17, 1959.

Credit will be given by the Maryland Academy of General Practice for attendance at these scientific sessions.

The complete program will be mailed to all members prior to the Meeting.

**IT'S YOUR MEDICAL SOCIETY MEETING—ARRANGE YOUR SCHEDULE
EARLY SO THAT YOU MAY ATTEND!
APRIL 15, 16, and 17, 1959**

APRIL 15, 16, and 17, 1959

ANNUAL MEETING OF MEDICAL AND CHIRURGICAL FACULTY REMINDER—HOTEL ROOM RESERVATIONS

A block of rooms has been set aside at the Sheraton Belvedere Hotel, Charles and Chase Streets, Baltimore, for those attending the Annual Meeting of the Medical and Chirurgical Faculty in April. The Hotel will take your room reservations *now*. When making your reservation be sure to mention that you will be attending the Annual Meeting of the Faculty.

SOUTH BALTIMORE GENERAL HOSPITAL ISSUE

SOUTH BALTIMORE GENERAL HOSPITAL

DONALD T. MILLS*

South Baltimore General Hospital, dedicated to the furtherance of good community health, fulfills an important role in the family of hospitals in the Baltimore metropolitan area.

In 1901 Dr. Harry E. Peterman, an ophthalmologist and otolaryngologist, being aware of the great need to provide service for the poor, purchased a dwelling at 1211 Light Street for 13,000 dollars to house his patients and recipients of his benevolence. A more inadequate facility could not be imagined, but it did provide a service much needed at the time. This humble beginning was symbolic of the humanity of the founder of the South Baltimore Eye, Ear, Nose and Throat Charity Hospital.

The single operating room, sparsely furnished, was on the second floor of this makeshift hospital. No means of transportation was provided, and Dr. Peterman carried the patients from surgery to the first floor for recovery.

Dissatisfied with the physical inadequacies of the hospital and needing additional beds, Dr. Peterman prevailed upon his friend, Dr. James Bordley, Jr., and local citizens of the South Baltimore area to join forces for much needed improvements. This led to the formation of a Board of Trustees and eventual incorporation in January, 1904.

Following this turn of events, extensive physical improvements were undertaken. This precipitated the formation of a visiting staff. In 1911, with increasing demands by the public for service beyond eye, ear, nose and throat, the visiting staff started working toward recognition as a general hospital. A building fund was created in 1912, and with it its first drive for 50,000 dollars.

In 1915 the first wing, containing 35 beds, an accident room and clinic area was opened. This was followed closely by the conversion from a specialty to an acute general hospital. Prior to and including this formative period of hospital development, the hospital staff included such prominent medical men as Harvey Beck, Emil Novak, Walter

D. Wise and many others who through the years have contributed much of their time and effort to make South Baltimore General Hospital a credit to the family of Baltimore hospitals.

With ever increasing demands for hospital facilities, additions were completed in 1920, 1927, 1939 and, most recently in 1951, bringing the bed capacity to its present complement of 184 adult beds and facilities for 24 newborn.

During these memorable years South Baltimore General Hospital experienced many heartaches, one of which was the closing of the School of Nursing. This was primarily brought about by financial problems and secondarily by the inadequacy of facilities for a greatly expanded nurse training program.

Unfortunately, the expanded hospital plant was not based upon a long range integrated departmental program, but on the specific needs existing at the time. Functioning efficiently and accredited, the physical plant is far from satisfactory, measured in modern terms of hospital service and economy.

I have pointed out quite briefly the objectives of the hospital at its inception, probably with a nostalgic view, but primarily as an explanation for a vision of future growth which is in the making.

Slowly but steadily plans in this ever-changing hospital scene are taking place. Acquisition of a site for construction of a new hospital is now a reality. Preliminary drafts for a new and greatly enlarged hospital have been submitted by our architect. The medical staff, with its usual enthusiasm, is aiding immeasurably in bringing a new facility into reality.

With the untiring determination and effort exhibited by the Board of Trustees, under the leadership of Herman L. Gruhn, president, and the medical staff, under the competent and energetic leadership of Dr. E. David Weinberg, chief of staff, plans for a greatly expanded and modern South Baltimore General Hospital are advancing.

1213 Light Street
Baltimore 30, Maryland

* Administrator, South Baltimore General Hospital.

OLIVER SHAFFER LLOYD, M.D., F.A.C.S., F.I.C.S.

1884-1956

On May 27, 1958 the medical staff of the South Baltimore General Hospital honored its late chief surgeon, Doctor Oliver Shaffer Lloyd, by dedicating a bronze plaque in his memory. This plaque was executed by the well-known sculptor, Hans Schuler, and has been permanently installed in the Medical Staff Lounge of the hospital.

After its unveiling by Mrs. Frederick Stuart, Jr., daughter of Doctor Lloyd, the plaque was officially accepted on behalf of the Board of Trustees by its president, Herman L. Gruhn.

Doctor George McLean, who served as chief of medicine for many years and was a close personal friend, as well as professional colleague, of the late Doctor Lloyd, presented the following eulogy at the dedication services:

"It is indeed with a great deal of reverence and devotion, and with a sorrowful heart, that we gather here today to honor our beloved colleague, Doctor Oliver Shaffer Lloyd. I am deeply moved by your kind invitation in selecting me to make this most worthy presentation.

"I know that if he were here today, he would not want the eulogy that he so justly deserves. Unfortunately, there are no suitable words that could adequately express our sincere friendship and devotion to this wonderful person, better known to all of us as 'Papa Lloyd' and to many of his close friends as just plain 'Ollie.'

"Through his long, forceful, capable, and inspiring leadership he was a most valuable asset in the development and scientific progress of this hospital. He was a man of vision, courage, balance, simplicity, and kindness. His untiring efforts in disseminating sound, practical surgical judgments and opinions were a real source of enrichment to all of us who had the privilege of being closely associated with him.

"Through his keen sense of humor and his ability to relate his many amusing experiences, he had the wonderful faculty of becoming a friend to everyone he met. He rejoiced with his friends upon joyous occasions and, because of his sympathetic nature and easy approach, he shared the sorrows of his friends and even

his humblest patients. He was blessed with many humanities. He was never too busy or too proud to stoop or lift anyone, regardless of his station in life, to his own level of loyal and sincere friendship.

"Through his generous personality he helped many despondent patients, both professionally and financially, through their rugged paths in life. He achieved many honors and dignities, although his life was not free of disappointment, sorrow, care and worry. I believe, however, that the proudest moments of his entire life were his interest and loyalty to the Baltimore City Fire Department and to this institution; and his greatest pleasures stemmed from his devotion to this staff, his wife, his family and his friends.

"Everyone here mourns the loss of our dear friend. As a tangible expression of this I am pleased to present this plaque to the South Baltimore General Hospital from its medical staff, whose generosity and love and admiration of Doctor Lloyd impelled them to have it executed.

"I would like to close with the words of Oliver Wendell Holmes:

*Thou gracious God whose mercy lends
The light of home, the smile of friends;
Our gathered flock Thine arms enfold,
As in the peaceful days of old.*

*Wilt Thou not hear us while we raise,
In sweet accord of solemn praise,
The voices that have mingled long
In joyous flow of mirth and song?*

*For all the blessings life has brought,
For all its sorrowing hours have taught,
For all we mourn, for all we keep,
The hands we clasp, the loved that sleep.*

*We thank Thee, Father; let Thy grace
Our loving circle still embrace,
Thy mercy shed its heavenly store,
Thy peace be with him evermore."*

SCIENTIFIC PAPERS

AUTOMOBILE ACCIDENTS: THE MULTIPLE INJURY PATIENT

E. RODERICK SHIPLEY, M.D., F.A.C.S.*

The era of the high-speed, huge horse-powered automobile has changed the complexion of the injuries seen in the emergency ward. Today there are few automobile victims who present only one injury. The larger number of automobile accident victims sustain two or more injuries.

Often the physician in the accident room is confronted with more than one victim of an automobile accident brought in almost simultaneously. These numerous victims present multiple minor or major injuries in which immediate attention is necessary to save their lives. It is of paramount importance that the physician make the correct diagnosis and institute the proper therapy immediately. These decisions must be made in the confusion of a busy emergency room, amidst the noise of ambulance attendants, volunteer workers, nurses, orderlies, and friends and relatives of the injured. The examining physician and the admitting physician must be well indoctrinated to some plan of attack so that decisions of great magnitude can be made on a moment's notice.

In a total of 178 patients injured as a result of automobile accidents and who were injured seriously enough to require hospitalization at South Baltimore General Hospital, fractures of bones were by far the most common. There were 141 fractures in these patients. Minor lacerations occurred in 67 cases. Of the severe injuries, head injuries ranked first by far; 60 of these patients had concussion or a severe injury to the brain. Major lacerations occurred in only 16 cases; chest injuries in eight; abdominal injuries in six. In this series of 178 consecutive admissions as a result of automobile accidents, it was interesting to note that only one patient had facial injuries of any great extent and only one patient had an eye injury and this was a traumatic dislocation of the optic lens. Four patients suffered evulsion of teeth without severe facial damage.

* Surgical Department, South Baltimore General Hospital, Baltimore, Maryland.

In the past year, there apparently has been an increase in the number of fractures of the pelvis. There were 18 persons who sustained pelvic lesions of the 141 patients who sustained fractures, and of these patients, 12 were passengers in the automobile. A corollary of this observation is the great number of injuries to the lower extremities; in this series 55 of 141 fractures.

In spite of the severity and the multiplicity of the injuries seen as a result of automobile trauma, there are only three emergencies in which a matter of seconds may mean life or death. Respiratory insufficiency, hemorrhage, and cardiac failure or cessation need definite, heroic, and immediate attention.

Respiratory insufficiency may have its origin in one of four major areas: the mouth and trachea, the lungs, the pleural space and the pulmonary circulation.

If there is obstruction to the passage of air from the outside to the lungs via the mouth and trachea, a tracheotomy must be considered. A tracheotomy should not be delayed and should be considered as an emergency and as a simply performed procedure. There are available certain instruments, such as a Sheldon Tracheotome, which can be used to do a blind tracheotomy. In an emergency a large caliber needle can be inserted into the cricoid-thyroid membrane to allow some air into the upper trachea. Most commonly, the simple cleansing of blood and debris from the mouth and pharynx is sufficient.

The embarrassment of respiration may have its origin in the lungs. The occurrence of blunt trauma to the chest or lungs may cause an interstitial hemorrhage and pulmonary edema. Here positive pressure oxygen and supportive therapy, oxygen tent, or even endotracheal intubation and manual breathing may be necessary.

Respiratory insufficiency may be due to disruption of the pneumodynamics of the pleural space. Open sucking thoracotomy or a hemopneumothorax may prevent aeration of the lungs. In a sucking

wound of the chest pressure and occlusion of the wound with a dressing is usually sufficient. In treating the hemopneumothorax patient immediate tapping and aspiration is essential if the aeration is to be adequate. X-ray of the chest is of prime importance in any injured patient.

Respiratory insufficiency may be due to some traumatic interruption of the blood circulation through the lungs or to the lungs. Obstruction of the pulmonary venous system may occur in the severely injured individual and at times the administration of atropine sulfate immediately may overcome some of the massive vasospasm and aid in the prolongation of life.

Cardiac insufficiencies or cardiac cessation certainly is one of the most dramatic causes of death in the accident room or in the hospital. With cardiac cessation as an immediate occurrence in the accident room, opening of the chest and cardiac massage may be indicated if this can be done with reasonable ease and reasonable hope that life can be spared. Injection of adrenalin directly into the heart is usually tried but most commonly without avail. Injury to the pericardium with pericardial effusion is rare but does occur. If this is diagnosed by distention of the neck veins, low blood pressure, weak cardiac sounds and signs of injury over the precordium, tapping of the precordial area with a large caliber needle and aspiration of blood from the pericardial space may be life-saving. Post-traumatic cardiac insufficiency which could lead to cessation of the heart may occur as a result of injury or from some organic disease of the heart which existed prior to the accident. Here a history is nice to have, but the physician examining the patient must try to analyze the exact cause of cardiac difficulty and treat it accordingly without accurate history.

Hemorrhage can cause death rather rapidly. Overt hemorrhage is usually easily diagnosed and is easily treated. Pressure with the fingers over the vessel supplying the area or direct pressure over the bleeding vessel usually is sufficient. A tourniquet may be used, but in general it is to be condemned. Dr. Arthur Shipley used to make the statement, "Any surgeon has at his disposal ten instruments, any one of which properly applied, can control almost any hemorrhage." He would then hold up his two hands. The use of pressure to control hemorrhage is not to be overlooked.

The diagnosis of concealed hemorrhage is more difficult but should be suspected when the usual

signs of bleeding occur. Commonly, concealed hemorrhages occur from laceration of an intrathoracic or intraabdominal vessel. Here the area of injury should give the clue as to which vessel is damaged and appropriate definitive therapy should be instituted immediately. Delay in operating on a vessel which is bleeding is to be condemned.

After the three major emergencies have been eliminated a complete examination of the patient is essential. Patients brought in as a result of automobile accidents are, in many cases, quite uncooperative due to the excessive use of alcohol or because of head injuries. Under these circumstances it is extremely easy to overlook other injuries. Even in the well-oriented, cooperative patient who has undergone the confusion and hysteria of an automobile accident, there are areas which do not hurt and which do not point to injury which may prove, within 24 to 48 hours, to be quite disabling and even quite damaging to the patient. There are a number of patients seen in the accident room who complain of a broken shoulder, leg fractures, or massive lacerations and who do not complain of chest injuries, but on the following day pneumonitis will be present as a result of fracturing of ribs. The physician must carefully evaluate each patient for fracture of the cervical or thoracic spine. The whiplash type of injury to the neck is extremely common in automobile accidents and it is quite disabling. Fractures of the cervical spine are uncommon but can occur, and if overlooked, can have serious consequences.

In the average accident room, when more than one or two patients are admitted at one time, the physician must carefully consider which patient needs his services first. He should spend his time on the patient who is critically injured and whose life can be saved. It is unwise to spend hours of work on a patient who obviously is going to succumb to the injuries when the same time spent on another or several other patients could assure saving their lives. Those duties of the triage officer are difficult to learn but are essential knowledge for a good accident ward physician.

Once the patient has been examined and emergency treatment has been rendered, more definitive treatment is necessary before the patient is moved. A large caliber needle should have been inserted into a vein and the administration of an electrolyte solution begun in preparation for the administration of plasma or blood if indicated. The physician

should have performed a tracheotomy if necessary and in those cases of severe head injury where tracheotomy probably would become necessary.

All minor lacerations should be treated prior to transportation of the patients to the ward. These can be treated concurrently while other treatments are going on. The unconscious or semiconscious patient may have multiple small lacerations sutured without requiring anesthesia. It is the experience of the author that many clean, acute lacerations can be sutured without clean-up, without washing with soap or water, and without washing with antiseptics. The wound is simply sutured, sprinkled generously with Furacin Powder and a dry dressing applied. In 60 consecutive cases there has been no infection in these small clean lacerations. All abrasions must be cleaned if there is ground-in foreign material; if not, simple bandaging of these abrasions after covering them with Zeroform gauze or vaseline gauze is usually sufficient. Covering wounds of the face is unnecessary.

It is essential that the accident room physician who sutures the wound realizes that such lacerations may become disfiguring and that all care should be taken to properly approximate the edges of the skin. All dead devitalized tissue should be removed and the area sutured in the most cosmetic way possible. Lacerations of the face should be well inspected for their depth. Laceration of the parotid duct or facial nerve should be suspected in injuries over the cheek just anterior to the parotid gland.

The accident room physician should be sure that all fractures are properly immobilized before allowing the patient to be moved from the emergency room. In fact, all patients brought to the emergency room by the ambulance crews should be, and usually are, well splinted. If there is a fracture which is unsplinted, it is the responsibility of the accident room physician to be sure that this fracture is splinted prior to moving the individual. A patient in shock who has suffered a fracture of the femur quite often will not respond to therapy for shock until the femur has been well splinted. This is an essential in the treatment of peripheral vascular collapse.

Each patient should be inspected for injuries to arteries, veins, and particularly to nerves. Fracture patients before reduction should have the integrity

of the blood supply and the nerve supply to the extremity evaluated and recorded so that if there is a post-reduction paralysis claim, it will be well established that the injury occurred prior to and not during the manipulation of the fracture.

X-rays are essential in accident room practice, but X-rays should not be used in place of clinical judgment. The areas to be X-rayed should be judiciously explained to the X-ray technician. It is unwarranted to take X-rays of the entire body in place of a good physical examination. It is essential that the examining physician have access to the X-ray films or to a roentgenologist who can interpret the plates for him. An X-ray taken today and read three days later is not sufficient for emergency practice.

The administration of the indicated tetanus antitoxin or toxoid should be carried out in the emergency room. It is imperative that correct notation of this fact be made on the patient's record. If for any reason such indicated tetanus protection is not given, this, too, should be noted along with the reasons why it was omitted. The routine administration of an antibacterial agent is to be condemned. The institution of antibiotic therapy should be part of the more definitive therapy rather than emergency treatment.

The problem of admission of the patient to the hospital or conservative therapy on the outside is one that needs considerable thought. It is easy to overload a hospital by admitting all accident cases. Many cases admitted because of family desires or because of insurance could be well taken care of on the outside. The patient who deserves and requires hospitalization must be given it. It is the duty of the admitting physician to ask himself, "Is this injured patient injured severely enough to require hospitalization?"

SUMMARY

A brief outline of the general principles essential in the proper care of the multiple injury patient, the type most frequently occurring as a result of modern automobile collisions, is presented.

*Medical Arts Building
Baltimore 1, Maryland*

EXTRACRANIAL DIAGNOSTIC PROBLEMS ASSOCIATED WITH HEAD INJURIES

WILLIAM H. MOSBERG, JR., M.D.*

In evaluating the severity of a head injury the state of consciousness is repeatedly observed to determine its level. Alterations in state of consciousness following craniocerebral trauma recently have been described by Thompson (1). Although a progressively deepening state of consciousness is the most reliable indication of intracranial hemorrhage requiring operation; hemiparesis, pupillary inequality, slowing of pulse and respiration, and elevation of blood pressure should arouse suspicion of an intracranial hemorrhage amenable to operation. Restless or maniacal behavior following a head injury suggests the presence of a subarachnoid hemorrhage. The signs of a basilar skull fracture should be sought. These signs include spinal fluid (often bloody) escaping from nose or ears, swelling and discoloration of the eyelids usually associated with subconjunctival hemorrhage, and an area of contusion over the mastoid region ("Battle's sign"). Prophylactic chemotherapy is indicated in these patients. These general principles serve to guide one in the management of craniocerebral trauma. Not infrequently other injuries, which, if unrecognized, may lead to permanent disability or death of the patient may be present. A description of some of these injuries will be made and a means of diagnosis will be suggested.

The cervical part of the vertebral column is frequently injured when craniocerebral trauma occurs. Although paraplegia or quadriplegia is usually recognizable in an unconscious patient, neurologic deficit referable to nerve root involvement is difficult to detect. One can recall patients unconscious for days or weeks in whom a cervical fracture-dislocation has been demonstrated radiologically and who, upon regaining consciousness, have been found to have, for example, marked weakness of abduction at the shoulder, flexion at the elbow, or extension at the elbow. In certain cases in which headache has persisted for weeks or months after a head injury (the so-called post-concussive syndrome), Raney and Raney (2) have demonstrated that the headache may actually be related to cervi-

cal nerve root compression rather than to the head injury, with relief of the headache being obtained by treatment of the compression of the cervical nerve root.

An atlanto-axial fracture-dislocation frequently produces no neurologic deficit. These patients frequently seek medical advice days or weeks after injury with the complaints of stiffness and soreness about the neck. Although the positive findings on examination may be limited to the head being tilted a bit to one side, some limitation of motion of the neck, and perhaps some tenderness about the upper cervical spine, the roentgenograms may show a marked dislocation of the atlas on the axis with a fractured odontoid process. I recall a patient seen recently who had sustained a severe head injury and who was referred to me for repair of a skull defect. Although he offered no complaints referable to his cervical spine, he consistently held his head tilted a bit to one side. There was some limitation of motion of his neck. Roentgenograms of the cervical spine showed an atlanto-axial fracture-dislocation.

The patient who has a head injury should be examined for tenderness about the neck, limitation of motion of the neck, spasm of the cervical paravertebral muscles, motor weakness and reflex changes in the upper extremities, and areas of hypalgesia about the upper extremities particularly about the fingertips. Frequently the cervical part of the vertebral column is damaged in patients in whom there is a head injury combined with a shoulder injury. Roentgenograms of the cervical spine are recommended in all such patients even though there are no complaints referable to that area. Indeed it is good judgment to obtain roentgenograms of the cervical spine in all patients with severe injuries to the head.

Cardiac contusion is often overlooked especially when the patient is rendered unconscious at the time of injury. Unconsciousness following injury—usually presumed to be due to injury to the brain—may be the result of the state of anoxia produced by cardiac contusion. This lesion occurs most frequently when the driver of an automobile is thrown forward and his chest strikes the steering wheel.

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Although the symptoms and signs vary greatly, weakness, anginal pain, and a transient fall in blood pressure are common. Tachycardia of variable duration is the rule, but bradycardia may occur and may be thought to be an indication of increased intracranial pressure. Changes in the ST and T waves on the electrocardiogram are usually present, and in more severe cases Q waves may appear.

The patient's chance for survival may be forfeited by failure to recognize the presence of an intra-thoracic or intra-abdominal injury. Too frequently a state of shock or labored respiration is rationalized as being "central in origin." It is difficult to diagnose a rupture of the spleen, liver, or kidney in an unconscious patient. With the altered state of consciousness abdominal tenderness or rigidity may not be evident. The increased intracranial pressure by its effect on the arterial blood pressure may to some degree alter the state of shock which might otherwise be anticipated. In this paper it would be imprudent to attempt an authoritative dissertation on the diagnosis of intra-thoracic and intra-abdominal injuries. Each year a number of patients with severe head injuries die, however, and are found at autopsy to have a ruptured spleen, liver, or kidney, or a pneumo- or hemothorax, despite examination by a general surgeon and/or a neurosurgeon. Certain criteria should arouse suspicion of such an associated lesion. An aphorism which neurosurgeons find most reliable is that if a patient with a closed head injury is in shock more than one hour after injury, his shock is due to something other than the head injury. This, by definition, excludes profuse bleeding from scalp lacerations and should also exclude the drop in blood pressure sometimes seen immediately before death following a period of elevated blood pressure. It is the application of this principle, rather than any expert knowledge of chest or abdomen, which often leads the neurosurgeon to insist that some serious injury to chest or abdomen is present although clinical signs of such an injury are not evident. The respiration of the comatose patient with increased intracranial pressure is characterized by an inspiratory snore. When we see a deeply comatose patient whose respiration is quiet and of normal rate and rhythm, we must consider the possibility of brain stem contusion.

If, on the other hand, the respiration is characterized by expiratory grunting or groaning in such a patient, one should look to the chest or abdomen for a possible cause of altered respiration.

How then, if the shock or abnormal respiration is not "central in origin," should one establish their etiology? The patient should be examined for fractures of long bones, pelvis, and ribs, and for subcutaneous emphysema. Clinical and roentgenographic examination of the chest should be done. Clinical evaluation of the abdomen may be of limited value. Hematuria in a caught or catheterized specimen of urine is significant. A patient who was seen recently was unconscious from a severe head injury and had remained in shock for a prolonged period. Hematuria from a ruptured left kidney was present but she would have died had not her ruptured spleen been removed. Soon after injury in patients with a ruptured spleen there is a leukocytosis in the peripheral blood which is not accompanied by a fall in the hemoglobin or red blood cell count. Gershon-Cohen (3) states that with rupture of the spleen roentgenograms of the abdomen often may show: gastric dilatation, prominence of the rugae in the cardia, serration of the greater curvature of the stomach, downward displacement of the gastric cardia and the splenic flexure and the colon. Less frequently one may note displacement of the stomach to the right, elevation of the left dome of the diaphragm, compression of the fundus of the stomach, obliteration or increased opacity of the splenic shadow, and free blood in the peritoneal cavity. He recommends oblique films of the left upper quadrant be obtained, and, in certain cases, filling of the colon and stomach with contrast media, and repeated studies during the period of observation. Clinical examination of the abdomen may disclose tenderness and local muscular rigidity in the left upper quadrant of the abdomen. Repeated estimations of the hemogram and circulating blood volume may lead one to proceed with laparotomy. Some surgeons in these circumstances have done an abdominal paracentesis as a diagnostic measure to demonstrate intra-peritoneal hemorrhage. At best, however, this group of patients with combined injuries are most difficult to manage, suffer a high mortality, require the combined efforts of general surgeon and neurosurgeon, and offer a serious challenge to all who undertake their care.

Injuries to the head may include injuries to structures other than the brain or skull. In patients with considerable swelling about the face, a depressed fracture of the zygoma may easily be overlooked. Unless specifically sought, a fractured mandible or maxilla or bleeding into one of the paranasal sinuses may not be detected. Clinical and roentgenographic examination of these areas will avoid such errors. The supra-orbital and infra-orbital areas are frequent sites of impact and, in these circumstances, damage to the supra-orbital or infra-orbital branches of the trigeminal nerve are not uncommon. The patient complains of numbness over the appropriate area where one can demonstrate hypalgesia to pin prick. Spontaneous regression of symptoms is likely over a period of time.

Some brain injuries, presumably through an effect on the hypothalamus, may lead to gastric and duodenal erosion, bleeding, and at times perforation (4, 5). This usually becomes evident some days or weeks after injury and is not to be confused with hemoptysis or hematemesis in the early hours after injury. These symptoms may be due to injury to the nose or nasopharynx or may result from the escape of bloody cerebrospinal fluid through a basilar skull fracture down the nasopharynx. When hemoptysis or hematemesis is present following head injury and there is no cerebrospinal fluid rhinorrhea or otorrhea, otoscopic examination may disclose a bluish discoloration of the ear drum on one side. This may indicate the presence of a basilar skull fracture without rupture of the tympanic membrane.

On a number of occasions the clinical problem is rather stereotyped. This is a patient who is stuporous following a head injury, whose pupils are equal and react well, whose reflexes seem symmetrically normal, whose vital signs are good, and who, either spontaneously or in response to painful stimuli, moves all limbs well except one upper extremity. Evidence of injury to that extremity is not present. Because of the apparent weakness of the upper extremity, the possibilities of subdural hematoma, extradural hematoma, and cervical nerve root injury are entertained. Examination of the patient discloses a fractured clavicle on the side of the "paretic" upper extremity. It is therefore pain on movement of the upper limb rather than actual

motor weakness which causes the patient not to move it as much as the other limbs.

Lastly, I should like to mention the diagnostic problem which arises in patients with fat embolism associated with head injuries. Symptoms of embolic occlusion and infarction of the brain usually appear several days after injury and may consist of somnolence, restlessness, delirium, coma, as well as, in some instances, convulsions. Focal neurologic signs may be present. Although the source of fat embolism may be the subcutaneous tissues, the chief source is the bone marrow and accordingly is prone to occur in patients with fractures. The fat is carried through veins from the site of injury through the pulmonary circulation and then into the systemic side of the circulation. In a patient who, as a result of his head injury, has been unconscious since injury, the dyspnea, cough, and restlessness indicating pulmonary embolism due to fat may be absent or overlooked. With the deterioration in state of consciousness several days after injury, a subdural hematoma is suspected. Clinical differentiation may be quite difficult and exploratory trephination may be necessary. In some instances fundoscopic changes have been observed (6). In some instances fat may be demonstrated in the sputum or urine and rarely in the blood. The so-called "sizzle test," based on the fact that a drop of urine in the presence of fat will sizzle when heated on a wire loop, is of some value (7).

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IDIOPATHIC HEMORRHAGIC INFARCTION OF THE TESTIS IN THE NEWBORN

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Hemorrhagic infarction of the newborn's testis may result from torsion of the spermatic cord or, less commonly, it may result from an unexplained thrombosis of the spermatic vessels. The latter has been referred to as idiopathic hemorrhagic infarction of the testis.

Approximately 40 cases of hemorrhagic infarction of the testis in the newborn have been reported. Several of these were due to torsion of the spermatic cord. Nine cases of the idiopathic variety of hemorrhagic infarct have been reported previously.

Baby C. B. was born April 28, 1958 at South Baltimore General Hospital. Labor was not prolonged. Presentation was L.O.A. No trauma to the genitalia was recognized upon delivery. On routine examination of the infant by the obstetrician soon after birth, a hard mass was felt replacing the right testis. The scrotum had a bluish discoloration throughout. There was a small hydrocele of the tunica vaginalis on the opposite side. Chest X-ray was normal. Urological consultation was obtained immediately. This observer concurred with the impression of the obstetrician that the mass represented a tumor. The scrotal wall seemed attached to the testicle with dimpling of the anterior scrotal wall over the testis when efforts were made to move it. The spermatic cord felt indurated and thickened for approximately two cm. above the testis when it again became compressible.

The general physical condition of the infant was excellent. On May 1, 1958 surgery was performed. The testis was freed by sharp dissection from the surrounding scrotal wall. The testis appeared dark red. There was no torsion of the spermatic cord above the testis. The cord was quite firm immediately above the organ. It was soft and normal in character, approximately two cm. proximally. Believing the condition represented a testicular tumor, high ligation of the cord was carried out at the internal abdominal ring and the testicle was removed.

Postoperative course was uneventful. The patient was discharged on May 8, 1958.

Pathology reported that on gross examination the testis resembled a blood clot. On cut section no tumor was recognizable. Microscopic section con-

firmed diagnosis of complete hemorrhagic infarction with thrombosis of the spermatic vessels leading to the testis. Calcium in the wall of the vessel gave the impression that the process had been longstanding.

DISCUSSION

Tankin and Robbins have recently reported this condition. They also reported three other cases of hemorrhagic infarction in which torsion of the spermatic cord was present. The clinical features of the case of idiopathic hemorrhagic infarction that they reported and ours were quite similar. The testis usually is very firm, even stony hard, and often seems adherent to the anterior scrotal wall which is discolored bluish black. Usually there are no local or general signs of sepsis. Since torsion of the spermatic cord can produce the identical histological picture in the testis as the condition herein reported, differential diagnosis has to be made by surgical exploration.

Although it is admitted in the absence of infection no untoward sequelae would conceivably result from conservative management, confusion of the hard testis with tumor formation would seem to indicate surgical inspection. The fact that histological section demonstrated almost complete replacement of the testicular tissue with hemorrhagic infarction seemed to indicate little reason to allow the organ to remain and atrophy. Androgen function would be most doubtful.

SUMMARY

1. A case of unilateral idiopathic hemorrhagic infarction of the newborn's testis is presented. It is believed that this represents the tenth case of this condition reported. It is a different entity from intra-uterine torsion of the spermatic cord.

2. Clinical features of the condition are presented. Surgical treatment is advised.

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INJURIES OF THE HEAD AND FACIAL REGIONS

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Injuries to the head and facial areas encompass the same classifications as do injuries elsewhere; e.g. contusions, abrasions, lacerations, avulsions, burns, stab wounds, gunshot wounds, fractures etc. All of these must be dealt with as similar trauma elsewhere.

The first principle in the treatment of any patient who has suffered a trauma is to evaluate the patient as a whole. Is the patient comfortable? If not, make him comfortable, both by physical measures (lying him down, splinting the parts, etc.) and by the administration of needed analgesics and sedatives.

SHOCK

The next question one must answer: Is the patient in shock? The treatment of shock, present or pending, is the primary consideration in every patient. An adjunct, and equally important consideration, is the control of hemorrhage, without which one cannot control the shock. Every emergency (accident) room should be staffed with a cohesive team of house staff physicians, nurses and accessory personnel (orderlies, aides, etc.) so that the basic procedures necessary in any case can be evaluated quickly and promptly instituted.

It is often too late to draw blood for typing and cross-matching when one has delayed until the patient is in peripheral collapse. The shock may be irreversible. The blood pressure and pulse should be recorded at once on every patient brought in with an injury of any consequence about the head and face. These should be rechecked regularly during the period the patient is under care.

At the first signs of shock, intravenous fluids should be started, and blood should be drawn for hemoglobin, hematocrit, typing and cross-matching in preparation for the possible need for blood transfusion. It is imperative to treat all such patients lying prone on a table, notwithstanding the objections from the patient, and it is wise to have the patient in a head-low position if any manifestations of shock are suspected or anticipated.

If the patient is unconscious, one must maintain

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a clear air-way at all costs. The use of the mechanical suction apparatus is very valuable, and in general, such suction machines should be part of the armamentarium of every emergency (accident) room. If difficulty is being encountered in keeping the air-way free from obstruction, one should not hesitate to do a tracheotomy since it will probably be needed for the proper after-care of the patient. Not infrequently one succeeds in keeping the patient alive and the air-way clean while he is on the table, only to have him expire in the ward because the nurses cannot reach the obstructive secretions in the air-way. In such cases tracheotomy is preferable to temporary intubation. A properly performed tracheotomy can be electively closed after the need for it has passed and little or no cosmetic disfigurement will be evident.

HEMORRHAGE

Bleeding is present in practically every injury, but only becomes important if it is severe or if it occurs in certain vital areas. Bleeding within the skull or brain is always serious and often requires urgent neurosurgical intervention. Bleeding from the nasal cavity or the ear canal may denote fracture of the base of the skull. It is sometimes difficult to control, even with tight postnasal and anterior nasal packing. In fact, if the bleeding vessel is within the calvarium of the skull, such measures are seldom effective, and it is necessary to do an immediate ligation of the appropriate carotid vessel. In these instances it is almost always necessary to ligate the common carotid artery, even though this carries the attendant danger of possible hemiplegia. Therefore, it is always safer to ligate the external carotid artery first; if the bleeding is controlled, well and good. If not, one can then proceed immediately to the more serious ligation of the common carotid artery before the wound is closed.

If the bleeding is from a facial wound, normally the bleeder can be found and ligated or suture ligated. Sometimes, however, vessels become severed deep within the framework of the facial structures and ligation of the external carotid artery should be carried out without undue delay. To do otherwise may cost the patient his life.

TRAUMA TO SOFT PARTS

(Abrasions, lacerations, avulsions, etc.)

The diagnosis in these patients is self-evident. The wounds should be thoroughly cleansed and debrided of all foreign matter; otherwise pigmentation and discoloration of the scars may ensue with a poor cosmetic result. Alcohol (and alcoholic tinctures) should not be used in these wounds about the face and head because alcohol has a coagulant effect on the exposed tissue proteins: hence the resultant scar will be slow to heal and often thick and discolored. The use of mercurial or other metallic antiseptics is also to be avoided for similar reasons. The aqueous solutions of Zephiran® are preferred to the metallic (mercurial) antiseptics. Thorough cleansing with soap and water or with pHisoHex® and water is to be preferred.

In order to obtain a good cosmetic result, it is imperative that accurate tissue approximation be obtained. To accomplish this, one must gain the cooperation of the patient. When extensive suturing is required, the administration of an analgesic-sedative and the use of local anesthesia are recommended. In the case of small lacerations, it may be well to close the wound quickly by a few well-placed sutures without anesthesia. The suturing itself must be done with accurate approximation of the edges. A larger number of fine sutures are much preferred to a few coarse sutures. The end result will be worth the extra effort. It is recommended that 0000 or 000 silk or nylon on atraumatic needles be used whenever and wherever possible about the face and head. The least amount of catgut should be buried, consistent with the obliteration of all dead spaces and complete hemostasis. Early removal of sutures (every other suture on the third day and complete removal on the fifth day) will help prevent conspicuous scars.

Careful approximation of tissues at the mucocutaneous borders is essential for a good cosmetic result. If there has been damage to the parotid duct, the severed ends should be approximated over a strut, such as a silver probe or ureteral catheter. Following completion of the repair, the strut should be removed. If the parotid gland itself has been cut, every effort should be made to splint the facial area after careful approximation, in an effort to avoid a fistula. Damage to the facial nerve requires immediate repair. The use of tantalum foil to ensheath the cut ends after careful suturing has been recommended.

Proper prophylaxis against tetanus and secondary pyogenic infection is necessary here as elsewhere. In the case of obviously infected wounds, it may be better not to close them primarily, but to debride them thoroughly and to treat them until free of infection, when secondary closure can be carried out.

The treatment of burns is so highly specialized that no effort will be made to include this subject here. Suffice it to say that burns of the face and head are no different from burns elsewhere and should be treated in a similar manner, though more attentively to prevent ugly scarring and contracture.

FRACTURES OF THE FACIAL BONES

Fracture of the mandible is the most frequent fracture of the facial bones; the nasal bones, the zygomatic compound, and the maxilla are next in frequency in the stated order.

Fractures of the Nose

Because of the prominence of the nose on the face, injuries to this structure are extremely common and fractures of its bony or cartilaginous framework are frequent, especially in children and adolescents. Even injuries which do not result in fracture often lead to future deformity of the nose because the injury occurs when the nasal structures are not fully developed. Unfortunately, many such fractures go undetected because of the common misconception that fractures of the nose are associated with pain. To the contrary, fractures of the nasal bones are not accompanied by pain except (1) at the moment of impact of the traumatic force and (2) upon the application of external pressure over the fracture site(s). This is due to the paucity of musculature of the nasal structures. An almost constant sign is epistaxis, since practically every fracture of the nose is compounded, at least on the mucosal side. This often leads to extensive discoloration of the soft parts (ecchymosis). Emphysema frequently occurs as a result of crying or of blowing the nose forcefully before the mucosal tears have become sealed off; hence, air crepitus is frequent.

Fractures of the nose may involve either the nasal bones, the nasal alar cartilages, the septum, or any combination of these structures. Except in badly comminuted fractures, the arch formed by the two nasal bones is almost always displaced in

its entirety, so that there will be a medial depression of one nasal bone and a lateral displacement of the opposite one, with an associated externally visible deformity in the shape of a C.

It is important to differentiate recent fractures from old ones which have healed with visible external deformity. A careful history is one of the most valuable adjuncts to diagnosis. Roentgen examination of the nasal bones will usually reveal the fracture sites; however, it is often difficult to visualize a fracture of the nasal bones by X-ray, due to the appearance of the overlying bones of the skull in all views. In these cases, where the history and clinical findings indicate recent fracture, surgical intervention is imperative in spite of negative X-ray corroboration.

If the fracture is seen early and there are no complicating circumstances (shock or other injuries) which preclude surgical intervention, immediate reduction of the fracture, before excessive edema ensues, is always the procedure of choice. General anesthesia is preferred, with a posterior gauze pack placed in the nasopharynx, and the airway being maintained by the use of a Davis tonsil gag or by intubation. Topical anesthesia plus nerve blocking technic is sometimes satisfactory. However, where the fracture is not seen until edema has occurred and is masking the true outlines of the nose, or where other extenuating circumstances exist, it is better to put off the operative reduction until the patient is in good general condition and until the edema has subsided.

Since the nose has no weight-bearing function, and there are no muscles which might displace the fragments, it is not necessary to effect immediate reduction of the fracture or to splint the nose in the interim. Most fractures are impacted and remain fixed: they produce no pain while awaiting reduction. If reduction is not carried out within two weeks, the deformity will almost certainly not be reduceable and a rhinoplasty will be needed. At the present time, we do not employ packing or splints at the time of reduction unless bleeding occurs or serious comminution exists.

Fractures of Zygomatic Compound and Maxilla

Fractures of the maxilla and of the zygomatic compound often occur together in cases of severe trauma, or may occur separately, with or without concomitant fractures of the skull or nasal bones. These fractures occur as a result of direct trauma

to the parts and are, hence, often compounded by the external force which produced them.

External deformity is generally quite obvious before edema of the overlying soft parts occurs. The edema which results is usually extensive and it is associated with discoloration due to extravasation of blood into the tissues. The presence of such fractures should always be either ascertained or ruled out by Roentgen examination, as the deformity may not be visible or palpable after edema of the soft parts develops. Early recognition is helpful in planning the management of these cases. All such cases should be hospitalized immediately, even if no operative reduction is carried out, as infection is always a serious problem. Therefore the immediate, prophylactic use of antibiotics is advised in preparation for surgery.

Fractures of the zygomatic compound are characterized by flatness of the affected area, causing an asymmetry of the face. There is usually tenderness on palpation over the fracture site and there may be palpable crepitus when the fragments are not impacted. Roentgen examination is most helpful in determining the character and type of fracture as well as the direction of the displacement. This information is needed to select the proper surgical approach for reduction of the fracture and correction of the deformity.

Fractures in the posterior aspect of the zygoma are best reduced through the temporal route, whereas those of the arch and anterior portions are usually easier to reduce by the oral route. In either case, fixation of the fragments after reduction is often difficult. Packing is feasible when the oral route has been employed: this can be done by the use of iodoform gauze or a Foley catheter. The latter has proven most satisfactory. External fixation by head splints is often required when the temporal approach is employed. Fortunately, many of the fractures reduced by the temporal approach can be managed without external fixation. When the fracture is compounded by external laceration of the overlying skin, direct reduction is usually the method of choice, supplemented by external fixation as necessary.

It is important in these cases to make sure that there are no other fractures of contiguous structures, such as the maxilla, the antral sinuses or the mandible. These may be missed because of the marked edema and ecchymosis, which often occur promptly after the injury.

Fractures of the maxilla usually involve the antral sinus. Whenever the antrum appears cloudy by X-ray examination, one must evacuate its contents by intranasal drainage to avoid infection and possible osteomyelitis of the bone. Fractures of the maxilla are usually compounded, at least into the antrum, and are often comminuted. In the latter instance, it is imperative to remove any loose fragments of bone, even when there is no apparent deformity, as otherwise the fragments will undergo necrosis and convalescence will be delayed by the resulting slough.

Maxillary fractures are best treated by open reduction via the Caldwell-Luc approach. This provides the most direct vision and the best cosmetic result, since the incision is made intra-orally and heals without visible scar. In addition, packing by Foley catheter or by gauze can be used to hold the fragments in place for as long as required (usually a week or ten days). It is necessary to protect the patient against infection by the prophylactic use of antibiotics.

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SPONTANEOUS CEREBROSPINAL RHINORRHEA AND OTORRHEA

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Leakage of cerebrospinal fluid through the nose and/or ear in association with basilar skull fracture is usually recognized promptly and treated appropriately. The occurrence of spontaneous cerebrospinal fluid rhinorrhea and otorrhea is, however, not widely appreciated; and when, in the absence of any traumatic episode, a clear and colorless fluid begins to escape through the nose or ear, the true nature of this fluid may not be immediately suspected. The purpose of this paper is to emphasize that cerebrospinal rhinorrhea and otorrhea may occur without any precipitating trauma by reporting two cases of the former and one of the latter.

REPORT OF CASES

Case 1. A. W., 35 year old white male, was admitted to South Baltimore General Hospital (#114393) on July 14, 1957 with delirium, headache, high fever, and stiff neck. Hemogram showed hemoglobin 15.4 grams, hematocrit 46, and leukocytes 21,500 with 85 per cent polymorphonuclear neutrophils. Urine analysis showed no significant abnormality and the serological test for syphilis was negative. Lumbar puncture showed cloudy fluid

under an initial pressure of 450 mm. The cerebrospinal fluid showed 3,033 white blood cells, 95 per cent of which were polymorphonuclear neutrophils, total protein 246 mgm. per cent, sugar 42 mgm. per cent, and chloride normal. Cerebrospinal fluid, blood, and nasal cultures showed no growth, but a throat culture yielded alpha hemolytic streptococci. Roentgenograms of skull and chest showed no abnormality. He was treated with penicillin and Chloromycetin® and had improved markedly by the day following admission. On July 17, 1957, the nuchal rigidity had disappeared and he complained very little of headache. He noticed that on bending his head forward when in a sitting or standing position, a clear and colorless fluid would drip from the right nostril. Upon questioning, he recalled that he had observed similar drainage lasting two or three days about one month prior to his hospitalization. He denied any history of head trauma and a review of the roentgenograms disclosed no evidence of skull fracture. The bout of meningitis responded well to treatment and his course was otherwise uneventful. A specimen of clear and colorless fluid dripping from the right nostril collected on August 1, 1957 showed four polymorphonuclear neutrophils, total protein 32 mgm. per cent, sugar 77 mgm. per cent, and serological test for syphilis negative.

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The patient was apprised of the gravity of the situation and surgical treatment of the cerebrospinal rhinorrhea was recommended. He refused further treatment and was discharged on August 7, 1957. Despite advice to the contrary, he has not been seen by us since that time.

Case 2. M. V., 37 year old white female, was admitted to the United States Public Health Service Hospital (#160152) on August 24, 1956. Eighteen months prior to admission she had a head and chest cold which was diagnosed as "flu" and which lasted three to four weeks. Following that episode, clear and colorless fluid dripped from her left nostril whenever her head was bent forward while she was in a sitting or standing position. One year prior to admission she experienced dizziness, stiff neck, fronto-occipital headache, and fever, and was treated with chemotherapy. These symptoms subsided within one week. For the next three to four weeks she had no drainage from her nose, but then it returned and remained present. During the 18 months preceding hospitalization she had several bouts of frontal headache with occasional chills and fever, and one bout of stiff neck four months prior to admission. There was no history to suggest a basilar skull fracture. She fell and struck the back of her head seven or eight years prior to admission but was not rendered unconscious. Roentgenograms of the skull including views of the base of the skull showed no abnormality. Roentgenograms of the sinuses taken on March 24, 1956 showed some thickening of the mucuous membrane of the right maxillary sinus, but X-rays of the sinuses taken on August 24, 1956 were reported as showing no abnormality.

General physical and neurological examinations were normal. A specimen of fluid collected from the left nostril was clear and colorless and showed no cells, total protein 22 mgm. per cent, sugar 72 mgm. per cent, and chloride 133 mEq. Cerebrospinal fluid obtained by lumbar puncture was clear and colorless, and showed no cells, protein 21 mgm. per cent, and chloride 115.5 mEq.

On September 12, 1956, under general anesthesia, through a left frontal exposure, the dura was dissected free from the bone and the floor of the left anterior fossa was exposed. There was no evidence of skull fracture, dural tear, or any other pathological process. The dura was then opened and the base

of the anterior fossa explored subdurally. Again no site of cerebrospinal fluid leakage or disruption of dura was found. A piece of gelfoam was placed extradurally at the medial portion of the base of the skull and another piece of gelfoam was placed subdurally under the frontal lobe medially and in the midline. The wound was closed. Her postoperative course was uneventful and she has had no further drainage of cerebrospinal fluid.

*Case 3.** J. G., 63 year old white male, was admitted to Mercy Hospital (#132499) on March 24, 1954. Two weeks prior to admission he had a slight cold and 24 hours prior to admission, he felt a "throbbing noise" in the left ear. He stated that 16 hours before hospitalization "a cupful of orange-colored blood" ran from his left ear. These symptoms were associated with a mild, dull aching in the left frontotemporal region. There was no history of head trauma. Except that his blood pressure was 182/90, general physical examination was normal. There was no abnormality on neurological examination. The tympanic membrane on the left had largely been destroyed and a slightly yellow fluid could be seen exuding from the left middle ear. There was no evidence of discharge from his labyrinth. There was no tenderness about the ear, mastoid, or temporal areas. The fistula test was negative. His hearing was only slightly impaired. The nose, nasopharynx, and sinuses were normal.

Blood studies were normal except for 18,350 leukocytes, 91 per cent of which were polymorphonuclear neutrophils. Urine analysis was normal except for a trace of albumin and an occasional white blood cell, epithelial cell, and granular cast. The serological test for syphilis was negative. The fluid from the ear contained 6.0 mgm. per cent sugar. Roentgenograms of the skull including special views of the petrous bones were reported by the radiologist as being normal except for some asymmetry of the petrous ridges and questionable thinning and rarefaction of the tip of the right petrous ridge. Considerable pneumatization of the petrous bones was noted bilaterally. Roentgenograms of the chest showed some clouding at the right base compatible with pneumonitis.

On April 13, 1954, under general anesthesia, an

* I am indebted to Dr. James G. Arnold Jr. and Dr. James J. Gerlach for permission to report Case 3.

endastral mastoido-tympanectomy was done on the left. The tympanic cavity and epitympanic space were filled with chronically infected granulation tissue. This was removed and the dural plate of the middle fossa delineated. The dural plate had been eroded by the inflammatory process producing a dural exposure of about one square centimeter. The inflammatory process had produced an opening in the dura, and cerebrospinal fluid was observed flowing from this site. A piece of gelfoam was placed in this area and the entire cavity grafted with split thickness skin taken from the thigh. Histologic examination of the skin of the external auditory meatus and the material from the tympanic cavity revealed scarring and chronic inflammation. His postoperative course was uneventful and he was discharged on April 29, 1954. There has been no further drainage from the ear.

COMMENT

In addition to the cerebrospinal rhinorrhea encountered as a sequel to cranio-cerebral trauma and infection of the paranasal sinuses, it has also been observed following intranasal surgery (8, 10) and in association with intracranial tumors (7, 15, 17, 21, 23, 26, 27). A number of authors (2, 6, 11, 22, 28) have reported their experiences with cases of spontaneous cerebrospinal rhinorrhea. This may be associated with spontaneous pneumocephalus (25). A number of these cases have been treated surgically (2, 11, 22, 28). Coleman and Troland (11) have defined cerebrospinal rhinorrhea as spontaneous only in the absence of: (1) trauma, (2) infection of bones of paranasal sinuses, (3) bone-eroding basal cranial tumors, (4) prolonged hydrocephalus, and (5) demonstrable congenital anomalies (nasal cephalocele, etc.). These authors enumerate as possible pathways for escape of fluid in cases of spontaneous cerebrospinal rhinorrhea: (1) persistence of the foetal craniopharyngeal canal; (2) persistence of lumen of the olfactory bulb, with fistulous opening along the olfactory nerves; (3) along sheaths of the olfactory nerves; (4) congenital defects in the cribriform plate with arachnoid extensions along olfactory nerve fibres. Coleman and Troland (11) regard the latter as the most likely cause.

It is recognized that cerebrospinal rhinorrhea may persist for many years (12, 24). In the practice

of neurological surgery one is frequently called upon to manage post-traumatic cerebrospinal rhinorrhea and otorrhea. When cerebrospinal rhinorrhea follows a head injury one generally assumes the presence of a dural tear in relation to a fracture involving the frontal, ethmoidal, or sphenoidal sinuses, or the cribriform plate. It is to be emphasized that such fractures are not always detected by radiological examination. When the fracture and dural tear establish a communication between the subarachnoid space and the mastoid or middle ear, cerebrospinal otorrhea usually results if there is a defect in the tympanic membrane. In the presence of an intact tympanic membrane the fluid passes through the eustachian tube and, if the head is flexed, into the ipsilateral nares. Thus, in rare instances cerebrospinal rhinorrhea may result from a craniomastoid fistula (3, 13). This paradoxical rhinorrhea has been reported following surgery of the posterior cranial fossa (27). The danger of cerebrospinal rhinorrhea and otorrhea lies in the fact that ascending infection may result in meningitis. Cerebrospinal rhinorrhea may occur in the acute stage of a head injury or as a delayed complication of head injury (9). Likewise cerebrospinal rhinorrhea may recur after a quite prolonged latent period. One of my associates (5) recently treated a 33 year old man (University Hospital #083-2-19) who had been hospitalized for five months following an automobile accident in 1943. At that time he had a basilar skull fracture, rhinorrhea, and pneumococcal meningitis. The rhinorrhea subsided and he remained asymptomatic until December, 1955 when he noticed on bending forward a continuous discharge of cerebrospinal fluid from the left nostril. This symptom persisted until surgical repair of the fistulous tract in October, 1957.

Cases have also been reported in which cerebrospinal otorrhea developed seven years (14) and ten years (4) following injury. Case 3 reported in this paper does not represent "spontaneous" cerebrospinal otorrhea according to the criteria set forth by Coleman and Troland (11), in that the leakage of cerebrospinal fluid occurred as the result of destruction of tissues by a chronic inflammatory process. This is, however, the only case of cerebrospinal otorrhea in our experience which did not result from trauma.

SUMMARY

Two cases of spontaneous cerebrospinal rhinorrhea are reported, one of which was treated surgically. A case of non-traumatic cerebrospinal otorrhea resulting from a chronic inflammatory process is reported.

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SOUTHWESTERN SOCIETY OF NUCLEAR MEDICINE

The Southwestern Society of Nuclear Medicine will hold its fourth annual meeting at the Roosevelt Hotel in New Orleans, Louisiana, March 14-15, 1959.

TRAUMATIC CASES AND THE LABORATORY SERVICES

ROBERT B. WRIGHT, M.D.*

If trauma is considered in a somewhat restricted sense as meaning violent injury resulting in disruption of the tissues, it will be convenient in the laboratory to divide traumatic cases into two classes; viz., those not requiring immediate laboratory service and those that do.

Those cases that do not require immediate laboratory work will fuse quite imperceptibly with the usual hospital patients. From the laboratory point of view, work on these cases will be undertaken more for the purpose of detecting some important underlying condition than for the purpose of direct management of the traumatic condition. As an example, a person with a simple fracture may need to have his diabetes brought under better control if his fracture is to heal properly. Many traumatic cases will fall into this group. Since some delay in the laboratory service does not jeopardize these patients, there is no special difficulty in rendering the required work. This can be done by the regular technical force during the usual hours.

The second group of cases poses more of a problem because of the sudden demand for laboratory service. The services required by these cases are the same as those required by non-traumatic cases. Blood-loss is the same problem when donors are being selected, whether it is after traumatic laceration or bleeding peptic ulcer. Therefore, it follows that if the laboratory is prepared to cope with the non-traumatic cases, it will also be prepared for the traumatic cases.

It follows then that the director of the laboratory, with the aid of the entire staff and the hospital administration, must attempt to have reasonable coverage for the emergency case—be it traumatic or non-traumatic. In the absence of being able to give complete 24-hour coverage for all procedures, some type of compromise must be established. It is immediately conceded that this compromise will not be satisfactory to every physician under all circumstances, but physicians in general should realize the situation and help the institution with its effort to supply reasonable service. There are certain laboratory services that

seem to fall immediately into the group of emergency procedures. They are:

1. Urine for sugar, protein, acetone and chlorides.
2. Leukocyte and differential blood counts.
3. Blood sugar, chlorides, acetone, urea nitrogen (NPN), CO_2 and amylase.
4. Blood and other cultures. Smears for bacteria.
5. Selection of blood for transfusion.

It will be noted that some of the above procedures will need to be done frequently while others will be required at wide intervals. The question is: How can this service be supplied at any time? It must be understood at once that an unreliable test is worse than no test. When house physicians are available, they may be expected to supply the emergency coverage; sometimes medical students are used; finally coverage by the regular technical force may be considered.

Coverage by the house staff is apt to be the least satisfactory because of inferior basic training and because the frequency of some of the tests is too low for them to keep their technique. An intern may become proficient in doing a blood sugar, but if he does none for two or three months, he probably will feel that he has lost much and may not want his findings trusted. The intern tends to have little interest in such work because he feels it is "drudgery" and that he is being "used." In case the coverage is inadequate, it probably will go undiscovered until there is a test case.

The medical student on emergency laboratory procedures has more incentive in doing a good job and may have better basic training than the intern. He is in a difficult position, however, because he is serving two masters, the staff and his dean. If he is called at two A.M. for an emergency and he has an examination at nine A.M., he is indeed in a tight position. Even if it is only a lecture at nine A.M., he will be in no condition to get much out of it. When the hospital administration is willing to employ enough students so that there will be constant coverage by a man who is awake and on a definite shift, much of the above trouble will be avoided. However, then there will be the extra cost.

* Director of the Laboratories, South Baltimore General Hospital.

Twenty-four hour coverage by regular technicians remains the most desirable from the purely medical point of view. Coverage by technicians is used by many of the hospitals in the United States because interns and students are not available. In such hospitals, their coverage for emergency work may be superior to some hospitals where interns and students are used. Even when the administration is willing to stand the expense, it is difficult to get enough technicians to cover the 24 hours of each day.

When there is a sudden large emergency load, the regular technicians usually are willing to be called back to duty. To expedite this, it is suggested that the names, addresses and phone numbers of all the technicians be posted in the laboratory.

A patient dying as "the result, wholly or in part, of a casualty or accident, is a 'Medical Examiner case'"; and should be reported to him or his representative. When the hospital pathologist is the Medical Examiner or his representative he may find his duties divided. If he is not the Medical Examiner

he may require the cooperation of the Medical Examiner in order to meet his teaching obligations, satisfy the attending physician and cope with the legal aspects. There is usually no difficulty in dealing with these reasonable considerations when they are thoroughly appreciated by all concerned. It seems that there is less likelihood for trouble from the legal point of view when the hospital pathologist does not have divided obligations. The hospital, because of a high sense of duty to the general public, may be willing to excuse the pathologist while he is on some legal mission but this could present some difficulty when the case he is investigating happens to have been a patient in the hospital he is serving.

In summary, the traumatic patient will pose no special problem for the laboratory that is adequately prepared for the non-traumatic medical emergency. In the event of death, the traumatic case is likely to become a Medical Examiner case, and should be handled by the hospital pathologist with the legal as well as the medical aspects in mind.

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WHIPLASH INJURIES TO THE NECK

EDWIN DAVID WEINBERG, M.D.

There have been an increasing number of neck injuries in recent years. Most of them are caused by a collision in which a vehicle rams into the one in front of it. In fact, 15 per cent of all automobile accidents are caused by rear-end collisions. A collision from the rear throws a person seated in a car into the position of acute flexion, with maximum stresses at the lower cervical and lumbar areas. Acute extension usually follows, and there may be more than one oscillation of the head and neck in alternate flexion and extension. A concomitant concussion of the brain may be produced by the acceleration-deceleration mechanism.

The symptoms and findings may be local, in the neck or the low back, or they may be cerebral, with or without psychoneurotic overlay. In the acute phase, there is tenderness and spasm of the cervical muscles, producing pain and limitation of movements of the neck, also, in some instances, of the lumbar region. Often there is spasm of the

adjacent muscles. Symptoms of cervical radiculitis are not infrequent, with pain of varying intensity in the posterior cervical region, the occiput, the shoulders, the arms, anterior chest, and, occasionally, the jaw. At times, fleeting reflex and sensory changes in the upper extremities may occur. Persistent local referred pain results from subsequent organization of the edema and hemorrhage of the muscles and ligaments which cause pressure in and about the foramina with nerve-root compression.

When intervertebral disc protrusion occurs, local and neurologic changes are usually more marked. Lumbar and sacral radiculitis and protruded intervertebral disc may occur, but as a rule, the low back symptoms disappear within a few days or weeks.

Microscopic studies of cervical ligaments have been made to determine their relative elasticity. These studies reveal that the ligamentum flavum, the ligamentum nuchae, and the atlanto-occipital

ligaments are very elastic; the supra- and intra-spinous ligaments are somewhat elastic; the anterior ligaments, inelastic. The latter are, therefore, more likely to tear and produce pain.

Occipital pain may be due to compression of the greater occipital nerve or result from avulsion of the insertion of muscles and ligaments in or near the occipital region. At the time of the accident a cerebral concussion with a lapse of consciousness and/or a blinding or explosive sensation may occur. Immediately after the accident the person may be stunned, bewildered or dazed. Headaches may develop in minutes or hours. Marked neuro-muscular tension, irritability, insomnia, vertigo, recurrent headaches and mood changes are frequent. These symptoms tend to improve within a few days or weeks. However, with more severe symptoms from a neck injury, or when there is more pronounced emotional reaction or a predisposition to psycho-neurosis, the symptoms may recur or persist for many months. In the chronic stage, physical or neurologic findings may be less pronounced; but one must be careful not to be misled by their absence.

In suspected neck injuries, the patient should have careful X-ray examinations of the cervical spine in anterior-posterior, oblique and lateral views with the head in the upright position and in flexion and hyperextension. Normally there is considerable range of motion in the cervical spine; loss of a part or all of this motion causes alteration of the normal lordotic curve. Complete or segmental straightening is the most characteristic finding. When the anterior ligaments are overstretched, exaggeration of the lordotic curve may occur. Fractures of the cervical spinous processes, the so-called "Clayshoveler's" fracture, may be present. Studies have shown that most of the motion in the cervical spine takes place above the fifth cervical vertebra. Since the maximum compressing force occurs in this portion of the cervical spine, compression fractures, if present, are usually found in the fifth or sixth vertebrae. This also explains why cervical radiculitis is usually referable

to the lower cervical dermatomes. The majority of the cervical muscles and ligaments are inserted into the occipital area which accounts for the fact that this is the most common site of avulsion of the soft tissues. Pre-existing changes, such as arthritis or disc degeneration may be aggravated and the symptoms prolonged (as a consequence of the accident). In the chronic stage, lateral X-rays may reveal the segmental loss of motion of part of the cervical spine or evidence of disc pathology.

In a certain percentage of cases, psycho-neurotic tendencies lasting a month or longer may develop with symptoms similar to a post-concussion syndrome. It is difficult to prove whether or not there is actual organic damage to the neurons of the frontal lobe.

A detailed history should be taken and complete physical and X-ray examinations should be made, with the patient being fully informed of the nature of his injury. In the more severe cases, when the patient is emotionally disturbed with symptoms of concussion, or when fractures or dislocations have occurred, hospitalization is advisable with appropriate treatment. The milder or more moderate cases may be treated at home or in the physician's office with analgesics, sedation, cervical collar and intermittent traction.

When a cervical collar is used, it should be removed as soon as possible in order to prevent muscular atrophy. Local application of heat and muscle exercises can be most helpful. Fractures and dislocations should be adequately immobilized.

Aside from the organic pathology of a whiplash injury, one must not fail to take into account the personal reaction of the patient, which may make evaluation of the symptoms, treatment and recovery difficult. Injury of the head and neck is of particular significance to patients, and, as a group, they are more apprehensive, anxious and tense. Therefore, careful explanation of the nature of the injury and reassurance is of utmost importance.

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Baltimore 2, Maryland*

Component Medical Societies



ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY ELECTS OFFICERS

The following officers were elected to serve in 1959:

President: Dr. Leland B. Ransom, Cumberland

Vice President: Dr. Leslie E. Daugherty, Cumberland

Secretary: Dr. Carlton Brinsfield, Cumberland

Treasurer: Dr. Thomas F. Lewis, Cumberland



DRS. LELAND RANSOM, LESLIE E. DAUGHERTY,
CARLTON BRINSFIELD, THOMAS F. LEWIS

Delegates to the Medical and Chirurgical Faculty: Dr. Hilda Jane Walters, Frostburg and Dr. James Feaster, Oakland.

Alternate Delegates: Dr. Calvin Y. Hadidian, Cumberland and Dr. Adolph Wolferman, Cumberland.

Censor: Dr. Emmett L. Jones, Jr., Cumberland

Journal Representative: Dr. Leslie E. Daugherty, Cumberland

Nothing is so fatiguing as the eternal hanging on of an uncompleted task.

—William James.

EMERGENCY MEDICAL SERVICE IN GARRETT COUNTY

Mobile radio units have been installed in all doctors' cars and at the Memorial Hospital at Oakland. Service is being given throughout the 24 hour period. A similar two-way radio is also part of every private ambulance in Oakland and Friendsville,

Oakland's police emergency car and the Memorial Hospital administrator's car.

Garrett County is sparsely settled and only seven small communities are scattered throughout the county. There are no physicians in the towns of Accident and Bloomington, which formerly supported two physicians each.

PERSONALS

Dr. Hilda Jane Walters, Frostburg, is recuperating after undergoing surgery at the University Medical College Hospital, Richmond, Va.

Dr. Richard W. Trevaskis, Sr., Cumberland, is recovering at his home, following a recent illness.

Born to Dr. and Mrs. Robert Feddis, Cumberland; a daughter, Messa, on November 30.

Dr. Conrad C. Zimmermann, was voted an honorary life membership by the Medical Staff of the Memorial Hospital, Cumberland, on his retirement from practice.

IN SYMPATHY

The Allegany-Garrett County Medical Society expresses the sympathy of all its members to Dr. Harold W. Eliason, Cumberland, on the loss of his father.

MEDICAL STAFF OFFICERS—SACRED HEART HOSPITAL—1959

President: Dr. Leo H. Ley, Jr.

Vice President: Dr. Lewis Brings

Secretary-Treasurer: Dr. James P. Hallinan



DRS. J. P. HALLINAN, LEO H. LEY, JR., LEWIS BRINGS

The Sacred Heart Hospital now has 28 physicians on its active staff, nine on the associate staff and 17 on the courtesy staff. The consulting staff is com-

prised of: Doctors L. B. Mathews, W. A. Van Ormer, Wylie M. Faw, Jr., J. E. McLean, E. D. Weinberg and R. A. Reiter; honorary staff: Dr. C. L. Owens and Dr. F. A. G. Murray.

There were 406 major and 537 minor operations performed in 1958. No babies were born in the hospital during the year. Total admissions were 3,651, with 123 deaths and 30 autopsies. An average daily census of 107 patients and a total capacity of 140 beds shows a 70 per cent occupancy for the year.

The future is hidden even from those who make it.

—Anatole France

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

The annual meeting of the Baltimore City Medical Society was held on Friday, December 5 at 8:30, preceded by the annual dinner at the Maryland Club of Officers and Committee Chairmen.

About 100 members were in Osler Hall when the meeting was called to order. Weldon Wallace, the medical reporter for the *Morning Sun* was present. There was an air of hushed excitement from the very beginning. Dr. Kimberly gave his treasurer's report and projected the typewritten record onto a screen. This was a noble experiment, but the contrast was poor. Those behind the first few rows were unable to make out the printing. Dr. Kimberly explained that in his opinion the Society wasted too much paper, and nobody read the Treasurer's Report, anyhow. He also added that the Treasurer's Report could not be acted on officially until it had been audited. This will be done in June at the end of the fiscal year. Some in the audience conjectured loudly, "They don't want you to see it anyway".

President Firor decided that his report, next on the agenda, would be deferred until the counting of the ballots. He proceeded to call for the annual reports of the various committees. There was some muttering of protest that the reports had not been printed and so were not available for general examination as had been done in some prior years. This again was declared by the Chair as having been done because no one seemed to read the committee reports, anyway. They will be published in the *State Journal*.

Dr. Phillips started the verbal committee reports

with a lengthy report for the Joint Anesthesia Mortality Committee.

Among the more interesting ones were those by the Constitution and By-Laws Committee. Activity of this committee had been suspended for the year in order to await the redraft of the Faculty constitution and by-laws. Since the City Society and all component societies must accept the State Society Constitution it was felt that we should defer any changes in our own until we have found out what the State Society was drawing up. President Firor admitted that, as chairman of the State Constitution and By-laws Committee, he had influenced the City Society By-laws chairman, Dr. Paulson, in this regard.

Dr. Gluck's Committee on Emergency Medical Calls stated that it has had no problems with the 3,581 calls it handled during the year. Although 132 physicians are listed with the Emergency Call Bureau, only about 35 have been active. New members are wanted for the roster.

Dr. Seidel, for the Geriatrics Committee, spoke of problems of co-ordination and gave a review of current events and local progress in his field.

Dr. Goldsborough, for the Legislative Committee, declared that his committee had checked all legislation as directed and had effected liaison with the A.M.A. and the Medical and Chirurgical Faculty Committee.

Dr. Sullivan's Committee to Co-operate with the Magistrates stated that there had been two cases of death soon after arrest. This number in itself was small and the cause of the deaths had nothing to do with the arrest or treatment after arrest.

Dr. Garlick, for the Membership Committee, called attention to the effective recruitment from the various hospitals.

Dr. Trimble, for the Program Committee, reviewed the discussion of his committee with the Executive Board and noted the change of policy wherein the Sections were sponsoring the various meetings. He stated that good attendance at these sponsored meetings had more than justified the policy.

Dr. Lovitt reported on the Blood Bank Committee and was commended for the tremendous amount of work that had gone into the establishment of the Baltimore Regional Blood Center. This has required a great deal of co-ordination among a variety of organizations, but now it is an established fact.

Dr. Peter Safar, for the Committee on Resuscitation, recommended continuing the education of the proper agencies—Fire Department, Police Department, and hospital accident room personnel—in the matter of open airway resuscitation, which he has so far and so nobly advanced. He gave a list of the topics which he felt should be emphasized.

Dr. Gilmore, for the Sanitation Committee, reported that further meetings with Dr. Huntington Williams, commissioner of health, had been effective in that collection of garbage and trash will be included in the budget to cover the three hot weather holidays. This is a tremendous advance in the face of opposition by the mayor.

Dr. Lawrence Serra, for the Committee on Tuberculosis, called attention to the great dearth of social service workers. There apparently are sufficient physicians and nurses in the Health Department to handle the cases brought to them, but there is a tremendous lack of personnel for follow-up and contact investigation.

Dr. Trimble, reporting for the Committee to Cooperate with the Emergency Medical Service, said that some liaison measures and preliminary planning had been held, but that at a higher echelon meeting, considerable dissatisfaction with the state of affairs had been expressed.

Dr. Stacy, reporting for the Committee for Inter-Professional Relations, had investigated the problem of emergency pharmacy services. Some physicians have been unable to find drugstores open 24 hours a day, or for emergency calls late at night. Dr. Stacy, in a conference with the leaders of the pharmaceutical profession, determined that one excellent drugstore is well-known among druggists to be open 24 hours a day, and has been for many decades. It is situated near Pennsylvania Avenue in a hazardous neighborhood, and its existence in regard to all-around-the-clock availability is not known in exclusive suburbs. An agreement was reached to reactivate a list, brought out about ten years ago, of drugstores that would be available in the different sections of the city for emergency or 24 hour medication. This list will be checked and published in the near future.

Immediately following the committee reports, Dr. William H. Mosberg, Jr. obtained the floor and, after reading a clipping in the Baltimore *Sun* of a Report of the Committee to Investigate Elective Admission of Private Patients to the Baltimore

City Hospitals, asked why this Committee's report had not been included in the agenda.

President Firor replied that in the past week a minority report of this Committee had been received, making a final report of the whole Committee not available for this meeting. Dr. Mosberg then discussed the premature release of its report by a committee to the press before the Society had even received it. He moved that the release be declared not valid and to request the newspapers to publish such a statement. This was received with noisy enthusiasm in some quarters.

Dr. John T. King, Jr., Chairman of the Committee to Investigate the Admission of Private Patients to the Baltimore City Hospitals, rose to apologize for the premature release. He stated that he was under the impression that his telephone conversation with Weldon Wallace, *Sunpapers'* medical reporter, was a friendly, personal, unofficial one. He went on to say that his committee had had two meetings and no facts on which to base any condemnation were found. The committee members seemed to be in complete agreement after learning that Mr. McMillin, superintendent of the Baltimore City Hospitals, had denied a specific private pavilion was considered in the proposed expansion of the Hospital, and that there was to be no augmentation of private patients' admission beyond the restricted categories now in effect. Dr. King felt that Mr. Wallace was most sly and cagey in his ability to extract information over the telephone without appearing to do so, but he had to admit that he had told Mr. Wallace that they had found no facts. Later three members of the committee had telephoned him that they disagreed. Dr. King felt that no tangible evidence had been submitted to weigh against Mr. McMillin's denial.

Dr. Ross Pierpont stated that he was sure Chairman King was quite sincere as far as he had gone, but that more should be found out about admissions to the City Hospitals. Dr. Pierpont felt that the City Council, particularly Councilman Liss, was interested in this investigation. Many broad issues were involved and it should not be dropped. He agreed that Dr. King and his Committee had no secretary, nor power to hold hearings, or go into it deeply. Dr. Pierpont's idea was that the City Society should go to the City Council for mutual help in evaluating medical policies at Baltimore City Hospitals.

Dr. James G. Arnold reported an industrial insur-

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ance accident case that he had seen in consultation. In reviewing the history of his patient he found that he had received emergency care at the City Hospitals, then had been sent home and electively admitted four days later. He remained in the hospital over 20 days and full fees were paid by the insurance carrier to the City Hospitals. Professional fees were also paid. He felt that this was certainly a non-emergency on the face of it and, if there was this one that he had encountered without looking for it, there were probably many more.

President Firor at this point re-emphasized that the report was not completed and the investigation was still going on. President-elect Whitehouse moved to stop the debate and this was carried. Dr. Mosberg's motion to notify the press that the release was premature was then voted on. The wording was somewhat ambiguous to many members and, although the voice vote was very close, on written vote the motion lost 70 to 40.

President Firor proceeded with the election of officers for the coming year. This was ingeniously arranged. The yellow slips, which contained both slates, were to be marked by the active members present, placed in an envelope, the envelopes sealed, signed with the voter's name, and the envelopes turned over to tellers. Following the collection of the votes by the tellers, there was a large scale exodus.

President Firor continued with the business at hand. He gave his report of the activities of the Executive Board, including a recommendation of the Executive Board that the Baltimore City Medical Society underwrite a collection bureau, under the supervision of the Committee for Ancillary Services. The report of the committee and its appropriation of 10,000 dollars for the start of the bureau was gone into in detail. John Sargeant whose suggestion this is, was given the courtesy of the floor. He explained the idea for improving public relations that lay behind his suggestion. Many of the members felt that this was not a proper field for the Society, and the plan was defeated.

Dr. Samuel Morrison presented a resolution calling on the City Society, the State Society, the A.M.A., and the Accreditation Board to do away with required hospital staff meetings and certain aspects of medical record keeping that are obnoxious to local physicians who go to many hospitals. In the discussion Dr. Leo Brady said he felt the same way as Dr. Morrison did, but that any attempt to alter the requirements at this time was unrealistic in view of

the competition among small hospitals for house staffs. An amendment was passed and Dr. Morrison's resolution was enthusiastically endorsed by the Society.

The slate presented by the Nominating Committee was elected by a comfortable margin.

Dr. Koontz rose to present a gavel to President Firor. Dr. Firor introduced President-elect Dr. Samuel Whitehouse, who, in his happy, humorous vein, stated his first official act on January 1 would be to name a Committee To-Lower-The-Podium to his level. On this pleasant note the meeting adjourned.

* * *

The Executive Board met Tuesday, December 9 for its final meeting under the presidency of Dr. Whitmer B. Firor. Of the section chairmen who received notice of the meeting, only one was present.

The report from Dr. R. Walter Graham, Jr., chairman of the Committee to Study the Investment of Baltimore City Medical Society Funds was reviewed. It recommended that: A) the monetary balance should be invested rather than kept in savings banks; B) that professional investment control was not justified because of the limited amount of funds available; C) that the Society rent a safe deposit box for the storage of any securities purchased; D) that the treasurer of the Society be bonded (although it was not deemed necessary to bond the members of the Investment Committee); E) the Committee be empowered to manipulate the funds and make periodic reports to the Society on the condition of the funds without the necessity of seeking permission from the Society about each specific action.

Dr. Otto C. Phillips, chairman of the Joint Anesthesia Study Committee, discussed the significance of the delinquency of four hospitals which routinely are lax in reporting deaths within 24 hours of an anesthetic. The Board approved the letter to the hospitals emphasizing the following point: "No patient, hospital, or physician is identified at any meeting of the Committee and all staff members are invited and welcome to attend the discussion of the cases." It is hoped that this will encourage the four delinquent hospitals to fulfill their obligations in this regard.

Dr. Everett Diggs, secretary to the Faculty, wrote to the City Society regarding the resolution of the House of Delegates concerning routine laboratory services performed for private patients by the State

Department of Health. He suggested that the Baltimore City Medical Society might want to take similar action with regard to the Baltimore City Health Department or let the Faculty proceed on this level as well. President Firor pointed out that Dr. Huntington Williams, commissioner of health of Baltimore City, had long since stopped doing routine laboratory procedures for private practitioners and had, aside from blood lead determinations, confined laboratory procedures of the City Health Department to those dictated by good public health practice only. While the Board agrees most heartily with the resolution of the House of Delegates, it felt that action on the City Health Department level should also lie with the representatives of the House of Delegates where the action was taken.

The question of "medical hypnosis" as advertised by non-medically licensed individuals was discussed. The chairman of the Psychiatric Section, Dr. Gallant, now reports, on request, that as far as the Psychiatric Section is concerned this is medically wrong. The Section recommends that such procedures be disapproved by the Society. The Board agrees that the next step should be the prompt obtaining of legal advice from Mr. Anderson.

The interim report of the Committee to Investigate the Care of Private Patients at the Baltimore City Hospitals was felt to be inconclusive in view of the minority report. Since Dr. John T. King, Jr. had submitted his resignation prior to the business meeting because of necessary absence from town, the new Committee was appointed as follows: Ross Z. Pierpont, chairman, Dr. Edward F. Cotter, Dr. Worth B. Daniels, Dr. William H. Mosberg, Jr., Dr. Otto C. Phillips and Dr. Stuart D. Sunday.

A request was presented from the president of the American Medical Student Association, University of Maryland Medical School Chapter, for the appointment of a representative of the City Medical Society to its Advisory Board. After some discussion, Dr. Mark Dugan was selected to represent the Society. It was felt that our representative would be in a unique position to help students with the economic and personal health aspects of medical practice. These aspects are not ordinarily part of a scientific medical curriculum but the Executive Board considers them important in the background of the student physician.

A memorandum from the Ophthalmological Section of the Baltimore City Medical Society regarding

the visual requirements for automotive driving in the state was endorsed to the Faculty with hearty support. This action is geared to the state level. It was felt that, aside from endorsement, the City Society could not be effective in its support at city level.

Mr. G. A. Anderson, our legal counsel, advised us that the activities of a practical nurse peddling her own personal cancer cure were quite serious. He advised that we communicate at once with the state's attorney and attempt to stop this practice. Her method seems to be to seek a nursing assignment with a patient who is terminally ill with malignant disease. After establishing herself with the family, she complains of the ineffectiveness of the physician's treatment. After a time she offers, for a price, to prepare a "family remedy" which she alone knows.

It was found she had engaged in similar activities in Florida. The report from Florida stated that she had gone to a cancer research institute with claims and asking for facilities to test and prove the product. Although this reputable cancer research institute offered her the facilities for evaluation and testing of her material, for one reason or another, she never got around her self-imposed obstructions sufficiently to demonstrate anything.

BALTIMORE COUNTY MEDICAL ASSOCIATION

CHARLES H. WILLIAMS, M.D.

Journal Representative

The meeting of the Baltimore County Medical Association, Inc., was held Wednesday, November 19 at the Stafford Hotel, with President Clarence E. McWilliams presiding.

Dr. Reese introduced the speaker, Vernon M. Smith, M.D., associate in medicine at the University of Maryland Medical School, who spoke on "Peripheral Vascular Disease."

Dr. McWilliams introduced John Sargeant, executive secretary of the Medical and Chirurgical Faculty.

Dr. Pillsbury reported on the resolution adopted at the October meeting. He stated that the Board of Governors had met with Dr. Earle T. Hawkins, president of Towson State Teachers College and Dr. Thomas G. Pullen, superintendent of schools. At this meeting a joint press release was prepared in which the Medical Association stated it was not

its intent to criticize any individual or institution and regretted the publicity in the newspapers. Following this a meeting was held with the Council of the Medical and Chirurgical Faculty in regard to the publicity which was released by the Association of Professors. It was decided at this meeting that in light of the previous publicity the matter should be dropped.

Dr. Gessner presented the following names to be voted into active membership as transfers from the Baltimore City Medical Society: Dr. Elliott Harris and Dr. Harold A. Grott, both of 8100 Harford Road. It was unanimously voted that both doctors be accepted for membership.

Dr. Pierpont questioned whether or not, in view of attendance requirements, it would be possible to hold meetings on alternate Wednesdays and Thursdays. Night meetings and Sunday afternoons were also discussed. Following a discussion, it was decided that this plan would be given a six-months' trial beginning in June.

FREDERICK COUNTY MEDICAL SOCIETY

LOUIS R. SCHOOLMAN

Journal Representative

The regular meeting of the Society was held at the Frederick Hotel November 18. The outstanding

features of this meeting were the oyster and country ham dinner and the election of officers. The oysters were unusually good this year, particularly those on the half shell. The laws of physics governing space not being abrogated, even for oysters, your correspondent had to stop at two and a half dozen.

As we sat back replete, the election of officers was accomplished without debate. Those elected were:

President:	Henry V. Chase, M.D.
First Vice-President:	Thomas E. Stone, M.D.
Second Vice-President:	John M. Culler, M.D.
Secretary:	Thomas R. Reid, M.D.
Treasurer:	Norvell Belt, M.D.
Delegate:	L. R. Schoolman, M.D.
Alternate Delegate:	E. A. Dettbarn, M.D.
Censor:	Russell L. Guest, M.D.
State Planning Committee:	James B. Thomas, M.D.
Alternate State Planning Committee:	L. R. Schoolman, M.D.

The final business of the evening was the reading of the proposed new Constitution and By-laws. These, I am sure, will be well debated next meeting.

It's Time to Plan Now!!

for

Wednesday, Thursday, and Friday, April 15, 16 and 17, 1959

ANNUAL MEETING OF THE
MEDICAL AND CHIRURGICAL FACULTY

The Alcazar, Cathedral & Madison Sts., Baltimore, Md.



Obituaries



Bertram M. Bernheim, M.D.

1880-1958

Dr. Bertram M. Bernheim, a pioneer in cardiovascular surgery and a founder of the American College of Surgeons, died November 28. He was 78.

Dr. Bernheim was born in Paducah, Ky. and graduated from the Johns Hopkins Medical School, where he later became an associate professor. He practiced surgery for a year in Louisville, Ky. and studied two years in Germany before coming to Baltimore in 1908 to practice.

During World War I he was among the first soldiers sent to France. He was a member, and later commander, of the Johns Hopkins Hospital Base Unit, which became Base Hospital No. 18 of the American Expeditionary Force. He served as an operating surgeon in all American battles and earned a citation for his work with combat troops during the fighting around Chateau Thierry in the summer of 1918.

Dr. Bernheim wrote a number of books and articles on surgical subjects and in 1947 received a national award for his book, "A Surgeon's Domain." In addition to being a member of the Faculty and a founder and fellow of the American College of Surgeons, he was a fellow of the A.M.A. and a member of both the Southern Medical Association and the Surgical Research Club.

He is survived by his wife Hilda and three children, Mrs. Ned Hess, I. W. Burnham 2d, and Maj. Bertram Bernheim, Jr., USAF.

Abraham Joel Blechman, M.D.

1900-1958

Abraham Joel Blechman was born August 16, 1900, the second child of Ida and Max Blechman of Baltimore. He graduated from Baltimore City College in 1918 and from Johns Hopkins University, with a degree of Bachelor of Arts, in 1922. After starting medicine at Hopkins Medical School, he

transferred to the Medical College of Virginia, graduating in 1926. His internship was at Sinai Hospital in Baltimore from 1926 to 1928 in surgery. He followed this with a residency, 1928-29, in pulmonary diseases at the Montefiore Hospital in New York City. He was a member of Phi Delta Epsilon Medical Fraternity, The American Medical Association, Baltimore City Medical Society and the Medical and Chirurgical Faculty of Maryland, the Southern Medical Association, and the Maryland Academy of General Practice.

On opening his office in Baltimore in 1930, he practiced in the Highlandtown area. He entrenched himself deeply in the hearts of the community. Always active in civic and charitable affairs, he supported both church and synagogue wholeheartedly. Throughout World War II he labored effectively at the Selective Service's main induction station at the Armory.

In October, 1936 he married Hilda Rue, a Sinai nurse from Norfolk, Va. She shared his love of travel and together they visited and travelled widely in this country and abroad. He was always a quiet, retiring individual whose vocation and avocation were the practice of Medicine.

Health difficulties began in 1937 with the removal of a kidney stone. He was unable to practice for two years prior to his death on November 8, 1958. He is survived by a brother, Charles; three sisters: Mrs. Cecelia Rosenthal, Mrs. Rose Schochat, and Mrs. Mary Robenson; and his wife, Mrs. Hilda Rue Blechman, of 3426 Bank Street, Baltimore.

C. A.

William Emrich, M.D.

1879-1958

Dr. William Emrich, an Eastern Shore physician, died December 17 at the age of 79. He graduated from the University of Maryland Medical School in 1902. He moved from Baltimore to Hebron, in Wicomico County, in 1931, where he practiced general medicine until two months before his death.

Dr. Emrich is survived by his wife, Mrs. Anna Speary Emrich; a son, William S. Emrich; a daughter, Mrs. William Ashley; and two grandchildren.

Herman J. Giering, M.D.

1875-1958

Dr. Herman J. Giering, a retired East Baltimore physician, died November 25 at the age of 83. He was the son of the late Dr. Anna Giering, who also practiced medicine in East Baltimore.

Born in Rochester, N. Y., Dr. Giering received his medical education at the Baltimore University School of Medicine. He graduated in 1911. He was married to the former Agnes Schutler, who predeceased him.

C. Loring Joslin, M.D.

1887-1958

An outstanding contributor to the science of pediatrics, Dr. C. Loring Joslin died November 12 at the age of 71. Despite the cancer which caused his illness and subsequent death, Dr. Joslin carried on his practice, both in Baltimore and on the Eastern Shore, until August.

For 20 years, from 1930 until 1950, he was professor of pediatrics at the University of Maryland School of Medicine. As a research scientist he was one of the first physicians to show the value of B Complex vitamins in the diet of infants and children. He was also the first to show the value of pectin and dehydrated banana powder in the treatment of diarrhea.

One of his outstanding contributions was the early recognition of intracranial hemorrhage in newborn babies, treatment of which can prevent such complications as cerebral palsy or idiocy.

Dr. Joslin was born in Sudlersville, on Maryland's Eastern Shore. He received his medical degree from the University of Maryland. Subsequently he worked at the Johns Hopkins Hospital and the New York Post-Graduate Medical School. He interned at the James Walker Memorial Hospital in Wilmington, Del.

He is survived by his wife, Mrs. Hester Riddle Joslin, two daughters, two sons, a sister and 13 grandchildren.

John C. Osborne, M.D.

1916-1958

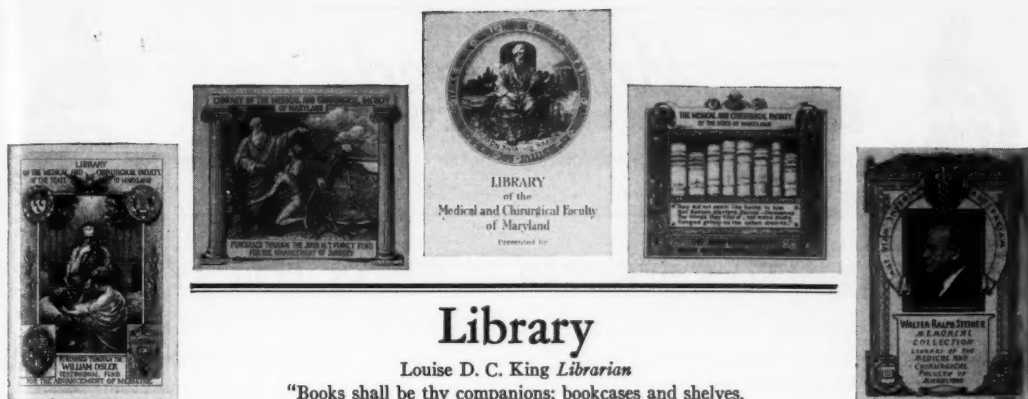
A heart attack on December 10 caused the sudden death of Dr. John C. Osborne, 42-year-old physician well known in Hamilton and surrounding communities, where he practiced. In addition to his private practice, he was a staff member at Mercy Hospital and a lecturer in medicine at Mercy's School of Nursing. He was also an instructor of medicine at the University of Maryland School of Medicine.

Dr. Osborne graduated from Loyola College with a Bachelor of Science degree in 1937 and studied medicine at the University of Maryland School of Medicine. Upon his graduation in 1942, he was commissioned in the Medical Corps Reserves.

During World War II he commanded an ambulance evacuation unit in New Guinea, took part in the D-Day invasion of the Philippines and served in Japan. He earned the Bronze Star in the Philippine campaigns.

After completion of his military service he began general practice in the Hamilton area of Baltimore. He is survived by his wife, the former Frances Martin, whom he married in 1943, a son, John, and two daughters, Ellen and Elizabeth. Also surviving him are his parents, a brother and two sisters.





Library

Louise D. C. King *Librarian*

"Books shall be thy companions; bookcases and shelves,
thy pleasure-nooks and gardens." *Ibn Tibbons*

REQUIRED READING

Understandest thou what thou readest? . . .
How can I, except some man should guide me?
St. John xix. 30

We are all familiar with Eliot's Five Foot Shelf; some of us with Sir William Osler's bedside library, as well as with many other lists made up for required reading. Some of these are read with the sole object of improving the mind, some for pure pleasure, a few out of curiosity, but most of them are read because they are required reading.

The little volume by Raymond Pearl, "To Begin With," published by A. A. Knopf in 1927, may be read for pleasure as well as for profit. It is presented in a fascinating manner and from a different angle than most such lists. It is in itself a classic and contains much food for thought outside of the suggested reading.

The listed books are intended for the graduate student in general science with biology particularly in mind. They have been selected not for their literary merit but rather for their impact on the mind. The volume is dedicated to Henry L. Mencken and one or two of his books are recommended, which should give you some idea of what to expect.

Seventy books, plus five additional ones for religious guidance, have been listed, as well as numerous others to which there is a passing reference. The chapter headings are indicative of the scope: "Why," "Wherefore," "Underpinning," "Living," "Biology," "Biostatistics," and "Epilogue."

We have chosen the first and last mentioned in each category to give you some idea of the catholicity of the selected titles. The first enumeration of recommended books begins with "Underpinning." Titus

Lucretius Carus' "De Rerum Natura" was selected because Lucretius was a pioneer in freeing science from the bondage of priesthoods and the superstitious fear of nature. The last in this chapter is François Rabelais. Under "Living," he begins with Baltasar Gracian y Morales' "The Art of Worldly Wisdom." "Any treatment," says Dr. Pearl, "of the conduct of life must start with the wise and worldly advice of that most urban of Jesuits." He ends with William Graham Sumner's "Folkways," "Undoubtedly the most important contribution ever made by an American to the science of sociology. This great book may fittingly bring to a close the chapter on the conduct of life." The first mentioned in the Chapter "Biology" is Galen's "On the Natural Faculties" because, "Every biological and medical student hears of Galen. Few read him." His last choice is Erik Nordenskiöld's "Die Geschichte der Biologie." In "Biostatistics" John Graunt's "Natural and Political Observations, Mentioned in the Following Index, and Made upon the Bills of Mortality, 1622" heads the list which ends with George Udny Yule's "Introduction to the Theory of Statistics." This last is recommended for rereading at this stage.

Dr. Pearl lays great stress on reading the books in the sequence given. Where it is known, he gives a good English translation with the publisher and date of publication. He tells you why each title is selected, more often than not, entertainingly. He cites Dr. Sydenham's recommendation of "Don Quixote" to the medical student who wished to read to lay a sound foundation in medicine.

There is nothing orthodox or pedantic in Dr. Pearl's selections. Possibly many will criticize them;

(Continued on page 81)



Maryland

SOCIETY OF PATHOLOGISTS INC.

LOUIS B. THOMAS, M.D., *President*

EDWARD C. MCGARRY, M.D., *Secretary*
Suburban Hospital, Bethesda, Md.



FALSE POSITIVE SEROLOGIC TESTS FOR SYPHILIS

The standard serologic tests for syphilis are only relatively specific for the treponematoses. Biologic false positive tests, therefore, do occur. These are customarily divided into two groups. In one group the tests revert to negative in a relatively short time, while in the other they persist for a long period, even for a lifetime.

The short duration false positive tests are usually associated with one of the infectious disease processes including smallpox vaccination, malaria, infectious mononucleosis, respiratory tract and other acute infectious diseases. Positive serologic tests from these causes revert to negative within three to six months after the acute illness.

The long lasting false positive tests usually occur in the absence of an obvious physical illness. Positive reactions of this type may sometimes accompany the diseases which have collectively been called collagen diseases. They include disseminated lupus erythematosus, arthritis, etc. Leprosy and chronic malaria may also cause persistent positive tests.

A positive serologic test for syphilis need not be regarded as an emergency, except possibly during pregnancy or in the presence of definite clinical evidence of active syphilis. Patients suspected of having a false positive test for syphilis should be systematically studied. A complete medical history should be taken with emphasis upon the venereal history and family history. A careful inquiry should be directed toward recent febrile illnesses or vaccinations which could produce a false positive serologic test. A detailed physical examination should be directed toward a search for the stigmas of congenital syphilis, a hidden and previously unobserved primary lesion either genital or extragenital, and physical evidence of systemic or neurosyphilis.

In the laboratory several titrated serologic tests with the ordinary lipid antigens should be obtained to exclude technical error. If these continue positive, spinal fluid should also be examined. Serum studies should include a treponemal immobilization (TPI) test, a treponemal complement fixation (TPCF), or a complement fixation test made with an antigen of the Reiter Treponeme (RTCF). Repeated, confirmed positive tests with treponemal antigens almost always mean syphilis. Repeated negative tests of this type constitute significant evidence that one is dealing with a biologic false positive phenomenon rather than with syphilis.

Tests with the treponemal antigens usually ultimately become negative in patients who have been adequately treated for primary or secondary syphilis, and are sometimes negative in tabes dorsalis, long-standing late latent syphilis, and late congenital syphilis.

If a collagen disease is suspected because of a persisting false positive serological test for syphilis, there should be included the following special tests: repeated search for L.E. cells, total protein and A/G ratio, serum electrophoretic pattern, the cephalin flocculation test, and thymol turbidity test.

Remember always, the possibility that a positive serological test for syphilis may be false. Take the time to be sure the patient has syphilis before beginning treatment.



The Heart Page

Gordon Walker, M.D. - Coeditors - Robert Singleton, M.D.

A SERVICE OF

THE HEART ASSOCIATION OF MARYLAND

SERVICES OF YOUR LOCAL HEART ASSOCIATION

Periodically your local heart association evaluates the changing needs of your community and refines its services to keep pace with the progress made in the diagnosis and treatment of those persons affected with heart disease. So that you may be aware of the services offered, this page is being utilized for their listing.

Since each local heart association is an autonomous group, each then tailors its resources to meet the needs of its particular community. However there are certain services offered by all the local associations because they fulfill a need felt statewide. These services may be arbitrarily divided into two general categories: community services and educational services.

The following are included under community services:

1. *Information and Referral Service*

This functions as a clearing house for any problems related to cardiac patients and makes necessary referrals to other community agencies.

2. *Loan Service*

Wheelchairs, hospital beds, etc., are made available to needy cardiac patients without charge.

3. *Camp*

Needy cardiac children are sent to a special camp yearly. Transportation and board expenses are provided.

4. *Work Classification Unit*

Teams of specialists are set up to evaluate work potentials of cardiac patients and attempt to place them in compatible jobs.

5. *Rheumatic Fever Prophylaxis Program*

Penicillin is supplied for rheumatic fever pro-

phylaxis at reduced cost for patients who cannot pay the full price.

Educational services are of two types: those for use by the physician and those for patient education. For the physician the following services are available:

1. *Postgraduate Cardiology Courses*

2. *Modern Concepts of Cardiovascular Disease*

A monthly digest of advances in cardiovascular diseases.

3. *Scientific Sessions*

4. *Audio-Visual Services*

Sound tapes and motion pictures are made available to medical groups.

5. *Educational Pamphlets*

(1) Examination of the Heart

(2) Recommendations for Human Blood Pressure Determinations by Sphygmomanometers

(3) The Work Classification Unit

A guide for its use in selective placement of persons with heart disease.

(4) Congenital Cardiac Defects

A physician's guide for evaluation and management.

(5) Diagnosis of Congenital Cardiac Defects in General Practice

(6) EKG Test Books

For the patient a number of pamphlets are available for distribution by the physician to help clarify the patient's disease process and describe the limits within which he should live. Following is a list of these pamphlets:

(1) Your Child's 'Strep' Throat

(2) Strokes—A Guide for the Family

(3) A Safe Work Load for Farmers with Heart Disease

(4) Varicose Veins

(Continued on page 81)



Blue Cross - Blue Shield



EXPERIENCE WITH AN OUT-OF-HOSPITAL DIAGNOSTIC PROGRAM

DENWOOD N. KELLY*

Members of the medical profession, as well as laymen, have often stated that Blue Cross could effect substantial savings by developing a program whereby diagnostic services would be available in doctors' offices or hospital outpatient departments. During the Blue Cross rate hearings last May, a number of physicians testified that, in their opinion, such a program would eliminate enough "unnecessary" hospital admissions to pay for itself, so that an increase in rates would be unnecessary.

Even before the rate hearings, Blue Cross had begun studies to determine not only the feasibility of such a program, but also its cost and the best way in which to offer it to the public. Fortunately we had readily available for study two years experience with a program which provided broad coverage of diagnostic X-rays, as well as special diagnostic medical procedures, whether done in or out of the hospital.

The local employees of one of the heavy industries have had, for some years, Blue Cross-Blue Shield coverage. Prior to September 1, 1956, these employees had regular Blue Cross coverage, but their Blue Shield protection applied only to hospitalized surgical cases. On the aforementioned date, in addition to a program of medical benefits for salaried employees (but not for those paid on an hourly basis), a liberal Blue Shield diagnostic program was placed in effect for *all* employees. It consists of benefits for diagnostic X-rays and the special diagnostic medical procedures of electroencephalograms, electrocardiograms and basal metabolic rates, done either in physicians' offices or in hospital outpatient departments. On these benefits there is a limit of 75 dollars per person in any consecutive 12 month period for those services rendered in doctors' offices, but no limit is imposed on those received in hospitals, either inpatient or outpatient. Thus, by comparing the hospitalization experience of this group of employees, which is large enough (averaging 123,000) to be statistically valid, for the year immediately

before and the two years after the effective date of the new diagnostic program, it is possible to get an excellent analysis of the overall effect of such coverage.

There are three major measurements of the utilization of hospitalization benefits. The first is the number of inpatient admissions per year per thousand subscribers at risk. The second is the average length of stay per admission, and the third is the average number of days of care used by each 1,000 subscribers per year. Of these the third is generally regarded as the most revealing as it combines the effects of the other two. It is particularly important to Blue Cross Plans as their reimbursement to hospitals for care furnished to subscribers is generally on a per diem cost basis.

In the 12 months immediately prior to the introduction of the diagnostic program, the inpatient admission rate among this group of employees was 97 per thousand. In the same period the next year, this rate had risen to 103 and the following year (September 1, 1957 to August 31, 1958), the rate again increased to 107. The average length of stay was 7.69 days per admission in the year prior to the new program and in the first year after its introduction, this rate decreased one-tenth of a day to 7.58; the following year, however, it increased almost one-third of a day, to 7.92. The number of days of hospital care per thousand subscribers increased at an even greater rate. In the 12 months from September 1, 1955 to August 31, 1956 this figure stood at 749; in the first year after the new program went into effect it rose to 784 and the following year it jumped to 850. These statistics are recapitulated for easier reference in the table which follows.

Summary of Utilization

	Sept '55- Aug. '56	Contract Years Sept. '56- Aug. '57	Sept. '57- Aug. '58
Inpatient admissions per thousand subscribers....	97	103	107
Average length of stay per inpatient admission (days).....	7.69	7.58	7.92
Days of care per thousand subscribers.....	749	784	850

The utilization figures for the new diagnostic program itself are also of considerable interest. Dur-

* Assistant Director, Maryland Medical Service, Inc.

ing the first year of the program, the utilization of diagnostic services was at the rate of 70 per thousand subscribers, with an average cost per service of \$18.65. The second year the rate of utilization increased to 111 per thousand, some 58 per cent higher, but the unit cost had decreased in only a minor amount, to \$18.11. The total cost of these services to non-hospitalized patients was \$161,377 the first year, and \$246,684 the second. The great bulk, some 77 per cent of this expense, was concentrated in diagnostic X-rays, over 83 per cent of which were done in doctors' offices.

In summary, the introduction of a program providing diagnostic care of non-hospitalized patients, despite relatively heavy utilization, has *not* caused a net decrease in the use of Blue Cross inpatient services by the covered segment of population. On

the contrary, the inpatient utilization has *increased rapidly* since the diagnostic program went into effect. Undoubtedly, one of the reasons for this increase is that the diagnostic program resulted in the detection of previously unsuspected diseases which thus created additional hospital cases. And this means better total health care, certainly.

This type of coverage is good and Blue Cross-Blue Shield are in favor of making it available to the community. But it is not wise to make such a program available under the misapprehension that it can be done at little or no additional cost. There is clear evidence that such a program will not reduce the use or cost of inpatient care. Therefore, while these diagnostic benefits should, and undoubtedly will be used heavily, they will materially increase the total premium cost of prepaid medical care.

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## Library

(Continued from page 77)

however they are not intended for the immature or unformed mind but for the serious graduate student who wishes a broad background on which to form his own opinions. To rock the cradle does not mean

the baby falls out. As Dr. Pearl says, "When young things begin serious graduate work, a solidly grounded general background upon which to build a sound specialism is what, generally speaking, they most completely lack." May we suggest that it is not only "young things" who could well profit by such reading!

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The Heart Page

(Continued from page 79)

- (5) Heart Disease and Pregnancy
- (6) Heart Disease in Children
- (7) Heart Disease Caused by Coronary Atherosclerosis
- (8) High Blood Pressure
- (9) Your 500 Milligram Sodium Diet

An anticoagulant identification card for emergency purposes is also available.

As stated previously, certain areas offer special services in accordance with local needs and facilities. Included in this type of service are the following:

1. Recreational Service for Children
2. Occupational Therapy Service
3. Social Service

The success of any program offered by your heart association depends largely upon the extent to which its services are utilized by patients, their families and the physician. The amount of participation is almost wholly dependent upon the enthusiasm of the local practitioner. If needed services and materials are lacking in your community, make this known to your local society and take an active part in bringing your local heart association abreast with current needs.

1527 Langford Road
Baltimore 7, Maryland

Health Departments

STATE OF MARYLAND DEPARTMENT OF HEALTH

The Health Program of the Maryland Commission for the Prevention and Treatment of Juvenile Delinquency

PERRY F. PRATHER, M.D.*

In May, 1956, Governor McKeldin appointed a Commission for the Prevention and Treatment of Juvenile Delinquency. The Commission was established to give leadership to the state in developing and advancing programs designed to stem the tide of juvenile delinquency.

The Subcommittee on Health of the Commission included individuals from general practice, pediatrics, obstetrics, psychiatry, public health, mental health, nursing, social work, education, psychology, the clergy and the public. After a year of intensive work the Subcommittee made a series of recommendations. As a preface to those it adopted, the Commission began with the following statement:

"The physical and mental health of families and their children is vitally important in the prevention and treatment of juvenile delinquency and in the protection of the community. In the provision of services for the prevention of juvenile delinquency and the treatment of delinquents, the family as a whole must be considered the unit of treatment. From prenatal care through adolescence a variety of medical services should be available to all children to prevent maladjustments and to insure the physical and mental health of our youth."

After a blanket endorsement of an increase and improvement in all regular health services for children, the Commission made specific recommendations for expansion in the areas of prenatal care, well-child care, school health and mental health services. These, together with some 300 other recommendations from the various committees concerned with child care, are embodied in the Commission's first report, "The Time for Action is Now," which appeared in August, 1957.

This year, in an effort to translate recommenda-

tions into action, the Commission has been holding a series of meetings in the counties of Maryland. The following legislative program contains proposals for the prevention of juvenile delinquency in the area of health. They are only a small part of the Commission's total program in this and other areas.† They are, however, concrete practical recommendations for which the Commission is seeking the support of the citizens of Maryland.

The Commission supports the budget of the State Department of Health in reference to the following items:

1. *A salary for a psychologist on a part-time basis to work in the well-baby clinics in Anne Arundel and Montgomery Counties to identify children showing deviations in normal growth and needing special follow up.*

This is a pilot project on the early detection of children with problems. The Department intends to extend this service to other counties as funds and local support are provided.

2. *The employment of a specially trained health consultant to provide diagnostic facilities in Frederick and Cecil Counties for the detection of certain types of exceptional children such as brain injured, gifted non-achievers, etc. The local boards of education will provide special classes and teachers for the instruction of these children.*

This is also a pilot project which succeeded last year in Montgomery County and is a step in the direction of identifying at an early age and treating children with handicapping problems.

3. *Salary for a chief of clinic services.*

This staff person will be assistant to the Chief of the Division of Maternal and Child Health. This Division has responsibility for consultation and supervision of maternity care programs and well-baby clinics. It will also have responsibility for the above projects.

4. *Increased funds for local health services including money for local mental health services.*

It should be noted that under the present method

† Legislative Program of Maryland Commission for the Prevention and Treatment of Juvenile Delinquency, September 1958. A limited number of copies are available from the State Department of Welfare, 120 W. Redwood Street.

* Director, State of Maryland Department of Health.

of financing local health services (the Case Formula), the State Health Department appropriations must be matched by local appropriations. Extension of child health services throughout the State will depend not only on additional State funds but on matching contributions from each county.

BALTIMORE CITY HEALTH DEPARTMENT

The Committee Report on Tuberculosis Control in Baltimore

Recognizing that tuberculosis in Baltimore City is perhaps the most costly public health problem among the preventable diseases with hospitalization and prevention activities running to an estimated three and one-half million dollars a year, the Commissioner of Health early in 1958 appointed a special committee to survey the City Health Department tuberculosis control program. The members of this committee were: Dr. Edward T. Blomquist, medical director, chief of the tuberculosis program, U. S. Public Health Service, chairman; Dr. Edmund Beacham, chief of the Tuberculosis Division of the Baltimore City Hospitals; Dr. Leon Hetherington, chief of the Bureau of Tuberculosis, Maryland State Department of Health; Frank Jones, executive director, Maryland Tuberculosis Association; and Dr. Philip E. Sartwell, professor of epidemiology, Johns Hopkins School of Hygiene and Public Health.

After a series of ten meetings the committee submitted its report to the Commissioner of Health on December 9, 1958 and a summary of its recommendations is given as follows.

Tuberculosis Case Finding

(1) That the existing diagnostic chest clinics be continued and strengthened.

(2) That the mass survey technique be employed in selected areas where the incidence of tuberculosis is demonstrably high.

(3) That the mass survey technique also be used for selected *groups* of persons who are readily accessible, providing that the anticipated yield will be in excess of one per thousand persons examined.

(4) That in all X-ray casefinding programs the survey procedure include the 14" x 17" diagnostic film technique for all persons placed under suspicion by the initial screening test.

(5) That in any survey planned on the basis of the above rules, the desirability and practicality of using the tuberculin test as the primary screening method should be considered, thereby limiting X-ray examinations to tuberculin reactors.

(6) That the Health Department exert greater effort in contact investigation, especially to improve the extent of examining adult contacts.

(7) That Health Department employees who are especially exposed to tuberculosis be examined at least once every six months.

(8) That through educational campaigns, medical society programs, public service appeals, and other methods, private physicians be alerted to the hazards of tuberculosis and enrolled as partners in the community's tuberculosis control program.

(9) That the Health Department assist general hospitals, chronic care facilities, and other institutions such as the City jail, to provide routine admission examinations for tuberculosis for all entrants into these institutions, and to provide for regular examinations for tuberculosis for the employees of these institutions.

(10) That the Health Department assist in the development of adequate casefinding programs among various municipal employee groups.

(11) That the Health Department stimulate the inclusion of pre-employment X-ray examinations or tuberculin testing programs in the general health programs of industry and commerce.

(12) That the Health Department promote annual X-ray examination of tuberculin reactors 15 years of age or older.

(13) That mass surveys in schools be discontinued in all but a few selected secondary schools—specifically those in which recent experience has shown that the cases found exceed one per thousand students examined.

(14) That all ninth grade students be tuberculin tested annually in order to provide an additional index of prevalence of infection throughout the City.

(15) That the Mantoux intradermal test be utilized in *all* tuberculin testing programs.

Tuberculosis Prevention

(1) That the Baltimore City Health Department participate in the U. S. Public Health Service study of the effectiveness of isoniazid as a prophylactic against tuberculosis.

(2) That contacts of those active cases who do not

enter the study, for reasons of the project's protocol or personal refusal, be tuberculin tested.

(3) That tuberculin convertors be treated if a lesion is concurrently observed. If a lesion is not observed the person should be kept under medical supervision and X-rayed again in three, six, 12, 18, and 24 months.

(4) That the Baltimore City Health Department, in view of (1) and (2) above, discontinue BCG vaccination of negative contacts of active cases of tuberculosis.

(5) That the vaccination of persons in high-risk occupations be the responsibility of the industries, agencies, or institutions that employ such persons.

The Tuberculosis Register

(1) That the tuberculosis case register be brought up-to-date so that it will reflect the current status of

tuberculosis patients in Baltimore City, with regard to hospitalization, medical supervision, activity status, bacteriological examinations, and drug therapy recommendations.

(2) That the prevalence of tuberculosis in the community be shown by annual tabulations, by machine methods, which will indicate the extent of supervision and care being given to the tuberculosis patients. Analysis of these tabulations should lead to improved program operation.

(3) That two clerks be hired to accomplish recommendations No. 1 and No. 2.

Huntington Williams, M.D.

Commissioner of Health

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APRIL 15, 16, 17

THE ALCAZAR
Baltimore, Md.

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MARYLAND TUBERCULOSIS ASSOCIATION

Christmas Seal Agency for State of Maryland

900 ST. PAUL STREET

BALTIMORE 2, MARYLAND

SOCIAL WORK AND TUBERCULOSIS

FRANK T. JONES*

Introduction

On these pages the Maryland Tuberculosis Association, grateful for the opportunity to bring to the physicians of Maryland information which we believe is of the utmost importance in modern tuberculosis control programs, will attempt to show how a voluntary tuberculosis association should function as an important link in the chain of diagnosis, treatment and recovery. The medical, psychological, and sociological aspects toward complete recovery will be emphasized.

"Tuberculosis is a social disease with a medical aspect." There is no question about the need and the value of medical social work in the hospital and the clinic to augment the very important medical care necessary for recovery.

Tuberculosis is found to be much more prevalent among the lower economic group of our society and, as with any long term illness, a family can become both socially and medically indigent in a very short period of time. A large percentage of patients diagnosed in the Health Department clinics need case work service and can use it constructively in making the necessary personal and social adjustments that are necessary if medical treatment is not to be blocked or retarded.

A great majority of patients still believe tuberculosis to be a fatal, incurable disease. They have little knowledge of the facts about the disease; add to this the psychological trauma of being told, "You have tuberculosis," or sometimes just "You have a spot on your lungs," and it is not difficult to understand why they refuse to accept the diagnosis or to accept treatment once they have been convinced that they are sick. A good well-conceived and cooperative social work program can help solve many of the patients' problems.

* Executive Director, Maryland Tuberculosis Association.

In 1946 the Maryland Tuberculosis Association instituted a full time medical social work program at the Druid Hill Health Center in Baltimore. This program has definitely proved that medical social work, if properly integrated with medical and nursing programs, can be of immeasurable help toward acceptance of diagnosis and treatment by the patient.

The kind of help the patient needs varies in nature and intensity. Patient problems requiring help in social service fall within the following major categories: financial, maladjustment of family relationship, housing, job concern, feelings about illness, and planning for medical care. A great amount of time and service is spent by the worker relating to the category of feelings about this illness. The worker has found that if she can visit and talk with the entire family, not just the patient, there is a better acceptance of the disease. Experience has shown that the sooner this is done after diagnosis the better the results. The social worker uses this family conference plan to help all concerned better understand the disease and their own resultant problems. She helps obtain financial assistance, child care in the home or child placement.

Many patients seen by the social worker are alcoholics; some have been in the hospital and left; some cannot or will not cooperate with the physician or nurse, but have, on occasion, been willing to accept the advice of the social worker. The alcoholic with tuberculosis is one of the big problems today and the association firmly believes that a good social work program, both in and out of the hospital, may be a partial answer.

Three of the State operated tuberculosis hospitals in Maryland provide in-hospital social work programs. Some financial support is given to the program by the Maryland Tuberculosis Association and its 22 associations. The success of a social service program in the hospital can depend a great deal on the attitude of the indigent patient at the time of his arrival in the hospital. If he has been well pre-

pared and is accepting hospitalization because he and his family know it is the best means of treatment, his prognosis is usually much better and he is less likely to leave the hospital against medical advice.

Today it is becoming an increasingly accepted practice to have the social service staff available to patients and to physicians and nurses. At the Druid Hill Health Center physicians have referred patients to the social worker immediately after the diagnosis has been made. The nurses seek advice and refer the hard core, uncooperative patient to the worker. A team program has been established which provides

opportunity to discuss various patient problems. Referrals sometimes come from relatives and family of the recalcitrant patient as well as from community agencies concerned with the patient and his family's welfare.

At the present time there is one social worker in the Baltimore City Chest Clinic Program; if funds are available it is hoped a second worker can be provided soon.

Tuberculosis remains the number one killer among communicable diseases in our state; to reduce this, all facets of diagnosis and treatment must be open and available to all patients. Medical social work is one of those facets.

MEDICOLEGAL MEETING SPONSORED BY A.M.A.

A regional medicolegal conference will be held at the District of Columbia Medical Society Headquarters March 20 and 21, 1959. Sponsored by the American Medical Association, it is one of three regional conferences designed to create a better working relationship between lawyers and doctors.

Subjects to be covered in speeches and question-and-answer sessions will include: narcotic addiction, traumatic neurosis, Res Ipsa Loquitur and medical professional liability, contingent fees, and impartial medical testimony. The program will be presented for a half day on Friday and a full day on Saturday.

A \$5.00 registration will cover the cost of the luncheon and a copy of the proceedings. Advance registrations should be mailed to the Law Division, American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

Other regional conferences will be held in Cleveland and Salt Lake City. This is the third year that meetings of this type have been sponsored by the A.M.A. According to C. Joseph Stetler, director of the A.M.A. Law Division, they have accomplished much in creating a better understanding between the medical and legal professions. "Medicine and the law must work together so frequently that we feel open discussions of mutual problems are imperative," he said.

THE TIME: *Wednesday, Thursday and Friday, April 15, 16, and 17*

THE PLACE: *The Alcazar, Cathedral & Madison Sts., Baltimore, Md.*

THE OCCASION: *Annual Meeting of Medical and Chirurgical Faculty*



THE MARYLAND ACADEMY OF GENERAL PRACTICE

(A constituent chapter of the American Academy of General Practice)

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J. ROY GUYTHER, M.D.
Mechanicsville, Md.

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3722 E. Greenmount Ave.

Baltimore 18, Md.



In this issue of the *Maryland State Medical Journal* a new feature is initiated. A monthly report of the activities of the Maryland Academy of General Practice will be presented.

The history of the Academy of General Practice begins in June, 1947 when 150 family doctors met in Atlantic City to draw up a constitution and set positive objectives. In non-parliamentary language, the Academy strives:

(1) To promote and maintain the highest standards of general practice.

(2) To encourage medical students to become qualified family doctors.

(3) To preserve the general practitioner's right to practice medicine to the full extent of his ability.

(4) To provide post-graduate training opportunities for the family doctor.

(5) To advance the science of medicine and the nation's health and welfare.

Today the Academy has more than 2300 members with chapters in every state, Hawaii and Puerto Rico.

To be eligible for active membership in this chapter of the Academy the applicant must be a physician engaged in the general practice of medicine and surgery. A general practitioner is defined as one who does not limit himself to one field of medicine or surgery. He must be of high moral and professional character. He must have been graduated from a medical school approved by the American Medical Association. He must be duly licensed to practice in the state and hold membership in the Medical and Chirurgical Faculty of Maryland. Candidates for membership who were graduated from medical school after January 1, 1950, must have had at least one year of rotating internship at a hospital approved for internship training by the Council of

Medical Education and Hospitals of the American Medical Association. In addition he must have completed one of the following:

(1) Two years of graduate training acceptable to and approved by the Commission on Education of the American Academy; or

(2) One year of graduate training acceptable to and approved by the Commission on Education, followed by two years of general practice; or

(3) Three years of general practice. Credit for military service is allowed.

The Academy of General Practice recognizes that no doctor ever *completes* his medical education. If he is to keep up with the progress in medicine he must continue to *study*. Consequently, the Academy became the first medical association to require continuing postgraduate education. Every three years each member must complete 150 hours of accredited study. If he does not satisfy the requirements he loses his membership. In 1957 six members were dropped from the Maryland chapter for failure to comply with post-graduate study requirements. This two per cent loss compares with the national average.

What does this organization offer its members? It provides at least five specific advantages:

First, the practitioner is given *incentive* to keep up-to-date with medical advances. He is given a *voice* in the settlement of current problems of general practice. He is provided with broad *opportunities* for continuing education. He has a comprehensive *insurance* program available, covering illness or accident benefits, professional liability, overhead and even retirement and annuity features. Finally he gains the *prestige* of membership in an active, progressive organization which each year receives greater recognition in the medical world.



Woman's Auxiliary Medical and Chirurgical Faculty



MRS. DAVID S. CLAYMAN, *Auxiliary Editor*



MRS. WILLIAM ROSS CAMERON

INTRODUCING THE PRESIDENTS

This is the second in a series of articles on County Auxiliary presidents. Featured this month is Mrs. William Ross Cameron, president of the Washington County Auxiliary.

Prior to her election to the presidency, Mrs. Cameron was recording secretary and chairman of the Committee on Mental Health.

She was born in Nova Scotia, Canada, and earned her A.B. degree at Dalhousie University, Halifax, N. S. She taught school in Nova Scotia until her marriage to Dr. Cameron in 1926.

The Camerons lived in Alabama, then in West Virginia, before coming to Hagerstown in 1930, when Dr. Cameron became city and county health officer. They moved to Baltimore in 1940 and back to Hagerstown in 1953.

Dr. and Mrs. Cameron have three children: a son

who is also a doctor and two daughters. They have three grandchildren. Mrs. Cameron's hobbies include reading and bridge.

DOCTORS' DAY

MRS. GERALD LEVAN

Doctors' Day, March 30, has been a project of the Woman's Auxiliary to the Southern Medical Association since 1935. Since membership in Southern is drawn from the 16 southern states, Canal Zone, District of Columbia and Puerto Rico, every state in the South observes Doctors' Day, and today almost every state auxiliary in our nation and its possessions participate in the observance of March 30.

Our neighbors to the south of us in Cuba celebrate a day in honor of the men and women of medicine fashioned after our Day of Commemoration.

China has had a custom of many years standing for each community to honor all its doctors on one day of each year. Not only all physicians, but the members of their families are feted and otherwise entertained by the communities in which they serve. There are many impressive demonstrations of the affection with which Chinese physicians are held by the entire population.

Doctors' Day is a special day set aside each year to honor the members of the medical profession, both living and dead, who have chosen a life of devotion to the art of healing.

The idea originated in Georgia by an auxiliary member in 1933. It was introduced to the Woman's Auxiliary to the American Medical Association in 1934 and to the Woman's Auxiliary to the Southern Medical Association in 1935. These organizations adopted the resolution and made a recommendation that each state celebrate an outstanding medical achievement in their own state.

The Governor of Maryland, the Hon. Theodore R. McKeldin, has, by proclamation, set aside March 30 to honor the men and women who, by daily devotion to their service to humanity, minister to our health and welfare—and by their constant



The State of Maryland

Executive Department

GOVERNOR'S PROCLAMATION "DOCTORS' DAY" March 30th, 1954

The importance and usefulness to humanity of medicine and surgery have increased through the years with each advance of the practitioners in the broad sphere of their knowledge.

We are living in one of the truly great ages of research and study. Long strides are being taken in the alleviation and curing of ancient ailments.

Never were the men and women of these and related sciences more devoted to the understanding and the practicing of their professions.

We already see the results in new attacks against old diseases, and the horizon is bright with new hopes--new faith in the skills and learning which God gives to those who choose the life of devotion to the arts of healing.

In Maryland--particularly in the metropolis of Baltimore--the world has one of its greatest centers for the developing and disseminating of advanced knowledge in medicine and surgery.

It is a distinction of which we are particularly proud.

With the cooperation of our fine surgeons and physicians, too, our State has developed a pioneer plan of rendering needed aid to our unfortunate citizens who are, through no fault of their own, indigent or unable to support their own needs for medical and surgical treatment.

It is our State's sound answer to those who would inflict upon our people as a whole the unwanted and unwieldy socialization of medicine which has crept into the society of less progressive nations.

In recognition of our State's leadership in research into human ills, its treatment of human diseases, and its advanced care of its citizens, and in gratitude to the great men and women of past and present who practice the professions of medicine and chirurgery among us, I, Theodore R. McKeldin, Governor, do hereby proclaim March 30, 1954, to be "DOCTORS' DAY" in Maryland.



GIVEN Under My Hand and the Great
Seal of the State of Maryland, at the
City of Annapolis, this 8th Day of
February, in the Year of Our Lord,
One Thousand Nine Hundred and
Fifty-Four.

By the Governor

John R. Reser
Secretary of State

study and research continue to learn more of the ways in which they can secure for all of us greater health and, through it, greater happiness.

Members of the Woman's Auxiliary salute our doctors, and applaud this proclamation by the Governor of our state.

March 30 is the *official* date for observance of Doctors' Day and is the *only* date for publicizing the tribute to your doctors. This particular day of the year commemorates one of the greatest discoveries for the alleviation of pain and suffering that our nation has produced. It was on March 30, 1842, that Dr. Crawford W. Long first used ether anesthesia in surgery. By honoring the great discovery of Dr. Long we honor all members of the medical profession.

The *red carnation* is the symbol of Doctors' Day and was adopted by the Auxiliary as the official flower in 1949. It is used wherever plans call for flowers in paying tribute to the members of the medical profession on this day. The analogy of the carnation is closely woven in medical science, so it is only fitting that this flower, so tailored by nature for masculine use with its spicy scent, was chosen as the symbol of Doctors' Day.

The flower—its meaning:

Divine—rejoicing—having appeared on earth for the first time when Christ was born.

Crown—coronation—denotes honorary distinction.

Its spicy fragrance was used in seasoning dishes "to preserve the body of men, both in mind and spirit."

From the juice of its petals a wine was made "that did comfort the heart of man."

The color: Red denotes Masculinity—Love—Charity—Sacrifice—Bravery—Courage.

It is hoped that the foregoing history will clarify the reason why Doctors' Day is observed and why honor is paid the members of the medical profession;

and particularly, why it is a day to pay tribute to the men and women of medicine *only*. Conceding the daily beneficent contributions to the well-being of mankind by members of other highly respected professions; nevertheless, Doctors' Day is a day of celebration for *only* Doctors of Medicine. March 30 belongs to them because an immortal colleague has indelibly engraved his glowing achievement upon the pages of medical history and in serving The Great Healer has become one of the greatest benefactors of humanity.

DID YOU KNOW. . .

That your Auxiliary has been on the air twice at this writing? Through the efforts of Mrs. John Marsh, president of our newly-organized Carroll County Auxiliary, Radio Station WTTR in Westminster (1490 on your dial) has allotted time to our Auxiliary on the program, "A Chat With Gladys." On November 26 Mrs. D. Delmas Caples spoke on "Future Nurse Clubs and Their Importance," and on December 9 our State President, Mrs. E. Roderick Shipley, spoke on "Auxiliary."

We are most grateful to Mrs. Marsh and to Station WTTR for this wonderful opportunity to build good public relations by letting people know what we are doing.

There are other programs coming. Watch for them!

Don't Forget Annual Meeting

PLAN NOW

April 15, 16, 17



VIRGINIA BEYER MEMORIAL LECTURE

The Department of Psychology, Springfield State Hospital announces that the Virginia Beyer Memorial Lecturer for 1959 will be Samuel Novey, M.D. The topic will be "Considerations on Religion in Relation to Psychoanalysis and Psychotherapy." The lecture will take place on April 17 at 8:00 P.M. in the Geriatrics Building. For further information write to Dr. Michael H. P. Finn, chief psychologist, Springfield State Hospital, Sykesville, Maryland.

Book Reviews

Convulsive Disorders of Children, Dora Hsi-Chih Chao, M.D., Ralph Druckman, M.D., Peter Kellaway, A.M., Ph.D. W. B. Saunders Company, Philadelphia and London, 1958. \$6.00.

This book is a revised version of a manual on convulsive disorders which the authors originally prepared for the use of residents in the Blue Bird Circle Children's Clinic. It is an attempt to provide a concise and simple review of diagnosis, treatment and management of the convulsive disorders and is based primarily on the data collected and developed in the Clinic since its establishment in 1949. The emphasis is clinical, but sufficient physiology and pathology data are given to afford the reader an understanding of the fundamental mechanisms involved.

Communicable Diseases, Vol. IV, Office of the Surgeon General, United States Army, Washington, D. C., 1958.

Throughout the histories of wars, communicable diseases have inflicted great losses upon armies and related groups essential to the military effort. During World War II disease ranked first among the three major categories of military casualties (disease, battle casualty and nonbattle casualty). It was, therefore, a significant drain on the operating efficiency of the Army.

The primary objects of this volume and two to follow are to indicate the magnitude of the communicable disease factor in the United States Army operations in World War II and to define and characterize the problems of communicable disease in military practice as distinct from those of civilian life. It contains a wealth of authoritative, detailed epidemiologic information, along with carefully collected and evaluated supporting statistical data, extensive illustrations, tables and charts. This book was written by 21 outstanding medical authorities, chosen because of their experience and distinction in their special fields.

What We Do Know about Heart Attacks, John W. Gofman, M.D. G. P. Putnam's Sons, New York, 1958. \$3.50.

Many people fail to carry through with a heart-attack prevention program because they really don't understand what their physician is trying to do for them. This book can perform a great service for the busy physician in explaining to his patients the background of heart attacks and why complete cooperation is essential. It is written in a simple and straightforward manner, stripped of medical verbiage, thus making it readable and comprehensible for the general population. It should prove to be most helpful in promoting patient cooperation with the physician's prevention program.

Difficult Diagnosis: A Guide to the Interpretation of Obscure Illness, H. J. Roberts, M.D. W. B. Saunders Company, Philadelphia and London, 1958. \$19.00.

This volume's sole claim to uniqueness is that it has been prepared by a single practicing internist and that it sets forth those diagnostic considerations which he believes should be readily available to the consultant clinician. The author undertook the writing of this book because he needed one like it in his own practice. It is not set forth as a "primer" on diagnosis; rather, its orientation is on an advanced postgraduate level for clinicians in the analysis of difficult case material. The author admits to many omissions. However, he considers the listing sufficiently panoramic so that those important, though uncommon disease entities which may apply to a given problem will be recalled. This volume is divided into two parts: 1) groupings of related diseases frequently producing puzzling illness and 2) classification and analysis of useful diagnostic procedures. In addition to a general index, it also has an index of signs, symptoms and laboratory manifestations.

Emergency War Surgery, NATO Handbook, United States Department of Defense, Washington, D. C., 1958. \$2.25.

While designed for military use in battle areas and evacuation hospitals, this manual is well adapted to traumatic surgery in civilian life as well. It is compact and concise. It is designed to fit in the pocket of a field uniform, and it is packed with practical information on the care of mass casualties. It is particularly applicable to civil defense and will be useful to physicians who, without special surgical training, may be called upon to care for trauma. Outstanding features of this book include a detailed description of shock, together with a clear and precise presentation of the components and amounts of replacement therapy indicated in special circumstances. There is a complete index.

The Birth of Normal Babies, Lyon P. Strean, Ph.D., D.D.S., F.A.P.H.A., F.A.A.A.S. Twayne Publishers, Inc., New York, 1958. \$3.95.

The major cause of defective babies, according to Dr. Strean, is stress, in one form or another, during the first three months of pregnancy. In this book he presents 60 case histories to support his findings. These case histories emphasize that the tragedy of congenital defects can be prevented in many instances.

COMING MEETINGS

NEUROPSYCHIATRIC SECTION, B.C.M.S.

AND

MARYLAND PSYCHIATRIC SOCIETIES

Joint Meeting

Thursday, February 12, 1959 1211 Cathedral Street

Speaker: Dr. Reginald S. Lourie, Associate Clinical Professor of Pediatrics and Psychiatry at The George Washington University, "The Problems of Personality Development in Brain Damaged Children."

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CANCER SECTION, B.C.M.S.

Wednesday, March 11, 1959 8:00 P.M. Baltimore City Hospitals

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SECTION OF INTERNAL MEDICINE, B.C.M.S.

AND

MARYLAND SOCIETY OF INTERNAL MEDICINE

Joint Meeting

Monday, March 16, 1959 8:15 P.M. 1211 Cathedral Street

Speaker: Thomas M. Durant, M.D., Professor of Medicine, Temple University School of Medicine, "Visualization of the Heart with Carbon Dioxide."

After the scientific portion of the program the Section of Internal Medicine of the Baltimore City Medical Society will hold its annual business meeting and election of officers.

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TELEVISION PROGRAMS, B.C.M.S.

Saturday, 5:00 to 5:30 P.M. WMAR-TV

February 14 "Tuberculosis," Dr. Meyer Jacobson

February 28 "Pregnancy," Dr. Hugh B. McNally